

THE REHABILITATION OF
THE PATIENT
SOCIAL CASEWORK IN MEDICINE



CAROLINE H. ELLEDGE

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OF
THE PATIENT

The Rehabilitation of the Patient

SOCIAL CASEWORK IN MEDICINE

By

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WITH A FOREWORD

By

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Philadelphia

London

Montreal

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Foreword

I SUPPOSE every writer of a foreword undertakes the task more or less reluctantly, chiefly because it is hard to convince oneself that it will serve any useful purpose. The value of a book must always depend upon what is contained in it and no amount of recommendation in a foreword is going to influence the reader as much as what he finds in it in the way of information, interest, or entertainment.

When I was approached by Mrs. Elledge with the request to write a foreword for her book I was of course flattered by the invitation, but I was very busy and did not feel that I should undertake any additional task, and particularly one that could be readily declined. But in this case, for two reasons refusal was not easy: First, my high respect for medical social service in general which has been of inestimable help to me in my hospital work, and without which my effectiveness as an orthopedic surgeon would have been greatly lessened; and, secondly, my high personal regard for Mrs. Elledge, whose work I have seen and admired during the years she was associated with the Division of Physically Handicapped Children of the New York City Department of Health, and also when she served as a fellow member of the National Council on Rehabilitation. In consequence I rashly said, "let me look at your manuscript," but always with the view of postponing and softening my refusal. I then made the mistake of taking the manuscript home and glancing through the pages. Very quickly, as I read, my interest was caught and I ended by sitting up late and reading every word. After that I was hooked, and I agreed to do the best I could in the preparation of a foreword. I felt that the message that Mrs. Elledge had to convey in showing the role that the medical social worker can play in a program of rehabilitation was so important that it deserved every bit of support I could lend it.

As an orthopedic surgeon with many years of experience in the physical reconstruction of the crippled and handicapped, and having become thoroughly inured during those years to tales of suffering and hardship, I was surprised to find that reading Mrs. Elledge's pages aroused in me so much interest and feeling. This reaction is explained by the use of case histories to illustrate the need for different methods of approach and for varied technics in the solution of the many different problems that are encountered by the medical social worker. These case histories are taken from real life and depict the many types of complex personality problems, the difficult family and social inter-relationships which make up the human comedy and tragedy of life. How frequently, even in the simplest case, the threads that tie people together become tangled, and how difficult it is to solve the problem until someone goes in to help sort out and unwind the various threads so that they can be fitted back again into an orderly pattern. Failure to understand that these problems lurk behind the scenes to a greater or lesser extent in practically every case accounts for many of the defeats encountered in the work. No one is in a better strategic position to hunt out these problems and to attempt to find their solution than the medical social worker. She should be the go-between in calling in the assistance of the various professional experts that are needed to help solve the problem, including the doctor, the technician, the psychologist, the psychiatrist and the vocational councillor.

I am reminded of the story told me by a friend, who is an orthopedic surgeon. It concerned a crippled boy who had practically grown up in a hospital during the many years he had had to spend there while the doctors were working to overcome a severe physical disability which made it impossible for him to walk. A number of operations were performed and finally these were successful and the boy was able to walk, and even to run and finally he was discharged from the hospital. Several years later, my friend, much to his chagrin, learned that the boy had been caught by the police as one of the members of a gang who had committed a carefully organized armed robbery, and

had been convicted and sent to prison. He regretted that all his labors and those of his associates, not to mention all the money that had been expended, had been wasted.

It seems to me that this case illustrates a successful program of physical reconstruction, but one that was not thoroughly co-ordinated with a broad program of rehabilitation. At this late date it is impossible to tell where the failure occurred but I feel sure that it would not have occurred if there had been a well trained medical social worker on the job. She would have served as a liaison between the boy and his family, and kept them together during all the years of separation. If that was not possible, or even desirable, because of the parents' characteristics, then she could have arranged for a psychological evaluation of the patient, seeking the assistance of the psychiatrist if that seemed advisable, and certainly could have had the help of the teacher and the vocational councillor in working out a program so that when the boy left the hospital he would have known what to do and would have had a reasonable hope of future security without resorting to the desperate means which he finally adopted.

From an experience gained in working with the professional and technical persons who are concerned with rehabilitation, I am convinced that no one is better fitted to make the early approach to the patient to win his confidence and investigate the family and social background than is the medical social worker. And then, with an understanding of the problems that confront the patient and with her knowledge of the community resources which may be used to assist the patient and the advice and help of the physicians who are directing the treatment, she should be able to steer the individual in a direction which will make him both a social and economic asset to his community. In the case of all handicapped individuals, the main effort is to build personalities whose strength is based on the physical resources and good qualities that remain rather than leaving them to depend on the sympathy and pity of well meaning, but uncomprehending persons who think only of their physical deficiencies.

It may be objected by some readers of this book that the medical social worker, as depicted by Mrs. Elledge, is too uniformly successful. While it is true that the author has been more concerned with presenting the successes of the medical social worker, than with her failures, I feel that this method is justified because she is trying to demonstrate the scope and skill of her profession in the difficult work of rehabilitation.

To the best of my knowledge this is the first time that it has ever been done. Of course, every case cannot work out as successfully as those described in these histories, but that does not mean that there is any the less need for the medical social worker, or that the failures are to be charged entirely to her account.

I consider this volume timely because so much is being written and spoken about rehabilitation and yet so few really understand what it is, how it works, or by what methods the results are accomplished. Of course, there is need for more and better rehabilitation, but it is a dynamic movement, and is gaining and expanding. The chief lack at present is the trained personnel to carry on the work.

Rehabilitation is a matter of teamwork and it takes years to train the individuals in order that they may play their full parts on that team. The team includes doctors, psychiatrists, psychologists, nurses, physical therapists, occupational therapists, medical and other types of social workers, teachers, vocational councillors and many others not least of whom are the employers. All are working toward a common goal which has been defined by the National Council on Rehabilitation, as "the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable."

I feel sure that every reader of this book will finish with a sense of need for the medical social worker in the rehabilitation team, and a better understanding of the importance of her field of work.

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Preface

THIS BOOK is a co-operative venture in which the author participated. The original plan, upon which the foundation of the book was laid, was formulated in a sub-committee of the Practice Committee of the American Association of Medical Social Workers. This sub-committee, set up to study the contribution of the medical social worker to the rehabilitation of handicapped persons, was composed of members from various parts of the United States who were working in a variety of medical settings. Their thoughtful consideration of the selection of case material and the preparation of the outline for original study cannot be individually acknowledged. To do so would risk identifying some of the persons whose rehabilitative needs have been used as case illustrations, even though every possible effort has been made to protect the privacy of the records.

When the Practice Committee suggested that the material be expanded into a book, an Advisory Committee under the chairmanship of Miss Beatrice Hall was appointed to provide guidance in the preparation of the manuscript. In the past two years both the quality and quantity of Miss Hall's help has been such that she should, in reality, be co-author of the book. It is with deep and humble gratitude that I repeat the well-known phrase "without her assistance the book would never have been completed." Other members of the Advisory Committee were Miss Muriel Gayford, Miss Elizabeth Rice, Miss Marian Russell, Miss Bessie Schless, Dr. Jack Masur and Dr. Hart Van Riper. To each of them, I wish to express by great appreciation for their individual consideration of the manuscript at various stages of its development. Miss Kathleen Allen, Miss Harriett Bartlett, and Miss Theodate Soule made valuable contributions as special consultants. Among others whose suggestions were particularly helpful were Dr. Leona Baumgartner, Miss Dorothy King, Miss Marian Martin and Miss Alice L. Taylor. Mrs. Dorothy Cooper

and Mrs. Jean Burgess were of considerable assistance to the author in the typing, editing, and proofreading of the material.

The preparation of the manuscript was aided by a grant from the National Foundation for Infantile Paralysis, Incorporated, to which organization the American Association of Medical Social Workers and the author are most grateful.

Last but not least, I should like to thank Dr. Philip D. Wilson for writing the Foreword. I can understand what he meant when he said he was "hooked" into assuming this task. I, too, was "hooked," by the challenge of the case material, into an attempt to put into words for those who offer and for those who use restorative services something of what may be involved in this process which we call "rehabilitation."

CAROLINE H. ELLEDGE

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1

Whose Job Is Rehabilitation?

"I'M ONLY 14 years old and I can't get along without my leg." If you were the one to whom this boy expressed his fear for the future, how would you try to help him? Many persons with permanent physical impairments secure help through all the usual ways in life—their own family, friends and relatives, church, school, physician and others who take a personal interest in them. An inspiring book could be written about individuals who have achieved satisfying lives without assistance from organized resources. The material in this book is presented from the point of view of medical social workers who have been and are a part of organized agencies, both voluntary and public. The purpose is to show not only how the medical social worker can be helpful but also something of the interweaving of organized efforts which become the pattern, or sum total, of help given an individual in his efforts to rehabilitate himself.

Who Needs What and Why?

Human beings are not identical, even though they may have the same kind of physical impairment. The rehabilitation needs of individuals will vary according to resources within themselves and their families, their social and cultural environments, the physical impairment itself, and the real opportunities which may be possible in the community in which they live. All kinds of services which are now available are being fully utilized by co-operative individuals who are at peace with themselves and working toward the objective of making their own best individual adjustment in the light of their potentialities and limitations. However, with some, the personal

From "Mending Wall" included in *Collected Poems of Robert Frost*. Copyright, 1930, 1939, by Henry Holt and Company, Inc. Copyright, 1936, by Robert Frost.

problems are such that they cannot take advantage of the services available to them. With others, personal troubles may be increased by lack of available services. And finally, with still others, their troubles may be increased by the way a particular service, such as institutional care for physical restoration, is offered to them. That is, the full implications of their needs as human beings, who must eventually complete the job of rehabilitation for themselves, may not be given consideration. Here, we are not interested in just describing the way people with physical impairments behave. It is the reason for their behavior which concerns us: Is it within themselves? Is it within their environment? How can some of these personal difficulties be prevented or diminished?

What Is Rehabilitation and How Is It Achieved?

According to one definition, "Rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable."¹ To achieve such restoration, the individual may need medical and surgical treatment; hospital, convalescent or sanatorium care; nursing, physical therapy, occupational therapy and special educational services. His co-operation is also necessary for psychological evaluations of his intellectual level and special aptitudes, for vocational guidance and training plans, and for consideration by employers. If he uses such services effectively, and many people do, he is likely to achieve as many satisfactions in life as any of us can hope for in the light of our assets and limitations. If he needs these services, but is unable to take advantage of them for personal reasons, his chances for rehabilitating himself are not so good. If he needs these services and they are not available to him, his desire to help himself will not create the facilities for his use. Successful rehabilitation, then, hinges upon two factors: Is what the person needs within his reach and, if so, can he reach for it?

If what he needs is not within reach, then we have a problem for community planning and joint effort to get the services to

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him. However, if he is unable to use facilities he needs which are available, the problem requires a personal solution. In many such situations the social caseworker can be helpful in working through with the individual the personal or family difficulties which prevent him from using restorative services. In some instances the failure to use services may be due to deep-seated personality problems which can only be dealt with by a psychiatrist. Sometimes the social caseworker can help people recognize the need for psychiatric treatment and pave the way for it. In other instances, the caseworker may consult a psychiatrist or psychologist on behalf of the person who has come to her. The social caseworker, like other rehabilitation workers, does not know all the answers and cannot perform miracles. When her services are available, however, the number of "failures to co-operate" may be appreciably reduced.

Where the Medical Social Worker Comes In

The medical social caseworker is a member of the professional team who may be available to the person with a physical impairment where he is receiving his medical care. If so, she may be called upon to offer her services to the patient. Her professional training has been directed toward helping individuals to work out those problems of social adjustment on which they wish and can use help. Sometimes the difficulties stem from within the individual himself, sometimes they are due to factors beyond his personal control, but usually they are a combination of both. It sometimes takes considerable skill, time and patience to find out what is troubling a person. Through interviews and discussions, the social caseworker helps the individual to bring out what his difficulties are and what may be the reasons for their existence. The purpose of social casework is to help those who are capable of self-direction to think through some of their troubles and work out the solution which is most satisfactory for them.

Knowledge of human behavior and understanding of the particular individual's difficulties make it possible for the case-

worker to determine whether or not efforts should be directed toward helping the person to understand himself better and thus learn how to manage his affairs with greater satisfaction; whether they should be directed toward helping the individual accept practical assistance which will relieve burdens he cannot carry unaided; or whether both kinds of services may be necessary. The successful use which may be made of social casework service depends, in part, upon the individual's ability to recognize certain difficulties in his life situation which he, or others, believes makes life less satisfactory for him. He may be unable to see his situation as a difficult one because he prefers to get along with one dissatisfaction in order to keep something else which he values. He may have personality difficulties which are beyond the scope of social casework and which require the services of a psychiatrist.

The medical social caseworker focuses her attention upon those personal problems which are related to illness or physical impairment. The person who is under medical care may not recognize, immediately, his need for this help. While referrals are ordinarily made by the physician who is directing medical treatment, other members of the staff, such as the nurse or admitting officer, may also call upon the social worker on behalf of a given patient. While she accepts referrals for her assistance from many sources within the medical agency and the community, she confers directly with the physician in making any plans with or on behalf of the patient which are related to his physical condition.

When the 14-year-old boy confronted the medical social worker with "I can't get along without my leg," the situation had come about something like this—

John O'Hara was admitted to the hospital for observation and diagnostic study because of severe pain and swelling in the knee joint. At the time of admission he seemed so worried about what the doctors might "do" to his knee that the medical social worker visited him immediately. She explained that she would come to see him often and that if he were worried about anything, she would be glad to have him tell her. The social worker knew that the father had died a few years earlier and that the mother had to

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work to support her two children. The mother was grateful for the social worker's interest because she was even more concerned than John as to what might be the reason for the pain and swelling in his knee joint. At first John had little to say when the worker visited. He was quiet and well behaved on the ward, amusing himself by reading and pasting stamps in his collection book.

A diagnosis of malignant tumor of the bone was established, and the doctors planned to amputate his leg above the knee. While they tried to avoid discussing John's case within his hearing, he was listening very hard and managed to piece together the possibility that his leg was to be removed, before they were ready to tell him.

Shortly after he had overheard enough comments to convince him that his leg would be taken off, the social worker stopped by to see him. She slowly led up to the subject of how he was feeling, after admiring his stamp collection and reviewing the merits of a book or two. Suddenly, he grasped his scissors and began to make snipping motions toward the bed spread. With difficulty, he told her he had overheard something about taking off his leg and said he wanted to run away from the hospital. The worker agreed with him that it would be enough to make anyone want to run away, and asked him what, in particular, he was afraid of. "I'm afraid it's going to hurt. Besides, I'll never be able to do anything any more." Tears came to his eyes and the words tumbled from his lips. He said that he would never be able to go to school again, could not return to his job as errand boy, would not be able to play games with the other boys. When asked why he thought this would happen he replied, "I am only 14 years old and can't get along without my leg."

The social worker explained to him, at this point, something about the use of an artificial limb and told him about other young men who had had a leg amputated but were able to return to all their previous activities. John seemed interested, but still thought he was "too young." The social worker said she understood that it might be hard for him to see just how much he could do, at this time, but explained that when the artificial leg was fitted he might be able to try to use it. He began to ask a few more questions about the amputation itself, and when the limb might be ready. He agreed that it would be good to ask the doctor about these matters. The social worker told him that after the operation was over, they could talk more about some of his future plans. She then talked with the doctor and explained John's great fear and his difficulties in discussing his concern. The doctor talked with John, explained the operation and answered questions regarding the artificial limb.

John made good progress after his operation and seemed to look

forward to going home. When he had been taught by the physical therapist how to use his artificial limb, the medical social worker arranged for him and his brother to go to a farm for a few weeks where he could "practice up" a bit before he went out on the street wearing his limb. There were a few occasions when panic again overwhelmed him and he thought perhaps he would not be able to play with his friends, after all. She helped him over these rough spots, too. The mother stayed home from work when John was discharged from the hospital, and wondered whether she ought not to give up her job so she could take care of him. The worker explained that this would not be wise, because John would not need any more taking care of than he did before, once he could use the artificial limb. Just before he returned to school, John had another touch of stage-fright, and thought that he did not want to go to school any more. The social worker prepared him to expect some curiosity on the part of his classmates. She thought that if John could just let his friends look him over, everything probably would be all right. At least a one-day trial would not be too difficult for a young man who had weathered the operation itself so well. He went, his friends were a bit curious and he found he wasn't too unhappy demonstrating his agility. The interest died down very quickly and he was in the routine of school within a few hours.

The physician had determined when it was safe to let him go to the country and return to school. John comes to clinic for regular re-examination, and when he does, he often stops in to see the medical social worker. John won a competitive scholarship to the private high school he is attending and it may well be he will win a scholarship to college, too. This is still an unknown quantity, but John will not be overlooked if he should need help in making future plans for himself. The high school has a vocational advisor and, when he reaches his senior year, if help is needed he will be referred to the Bureau of Vocational Rehabilitation through a joint report by the school and the medical center.

John and his mother had the help they needed at the time they needed it, and he came through this experience with flying colors. As is obvious, the rehabilitation process starts the moment it is known that a physical impairment is to be reckoned with in the future. John's fears about the loss of his limb were not glossed over, but rather he was helped to look at them and consider them from all angles. Gradually, he was able to think of himself as the same John who had previously led an

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active life with his family and friends, even though one leg was real and the other artificial. He anticipated the curiosity of his friends and was prepared for it. This helped him to meet their interest in an out-going, good-natured manner. He neither capitalized on his impairment nor did he withdraw into himself to nurse his hurts. Having made this return to every day living, it would be expected he could continue to look toward his own possibilities for the future. It is extremely doubtful that this young man will, a few years from now, put the artificial limb in the clothes closet, sew up his pant-leg to prevent it from flapping in the wind, and take to hopping around on crutches.

The Medical Social Worker as a Consultant

In the hospital setting, a medical social worker practices social casework and also sometimes acts as consultant to the teacher, the nurse, the vocational rehabilitation worker, or the social caseworker in the family or child welfare agency who may have a direct interest in the person receiving medical care for a physical impairment. Medical social workers are also employed by other agencies as consultants and to provide brief casework services where indicated. Not all hospitals have social service departments and not all persons with physical impairments are receiving medical treatment at the time they seek help from such organizations as a department of welfare, a division of vocational rehabilitation, a department of health, or a rehabilitation center, where medical social workers are employed. Then, too, a person with a physical impairment may be under the care of a private physician and receiving medical supervision in his office rather than in a clinic.

When the medical social worker acts as a consultant in a given organization, she uses her knowledge of medical implications and her casework skills to advise other persons in the agency on medical-social problems—difficulties in accepting the need for medical care, personal reactions to physical impairment and its effect on the service which is being offered, and so forth. She may provide such consultation services as a part of

in-service training for a staff of vocational counselors or nurses. This includes discussions of individual problems through conferences in which the staff worker brings records for discussion; or by an interview with the person concerned, at some strategic point, following which she confers with the worker who is to provide continuing service. Whether or not she provides direct service to individuals in these programs is influenced by the scope of the agency's services, the availability of casework services in the community and the nature of the problem.

The following is an illustration of service by a medical social worker employed as a consultant in a crippled children's service which included in its program an orthopedic diagnostic clinic.

Sam, a 17-year-old boy, reported to the diagnostic clinic because he wanted approval to work as a machine operator at a large industrial plant. When examined by the orthopedist he was found to have tenderness and limitation of motion in the knee. There was a small open sore above the knee. The orthopedist felt that Sam required immediate hospitalization. He told Sam he was not able to approve him for work, and, recognizing the young man's agitated state, walked with him to the office of the medical social consultant.

As soon as the doctor left the room, Sam stood up, glared at the social worker and made a comment to the effect that he not only did not want her help but had no time to waste talking to her. While he paused in flight, the social worker said she knew it must be a great disappointment not to be able to take advantage of such a good job. Sam stopped, looked at her and said with great feeling he wanted the job very much because it paid \$50 a week. He went on with the remark that even though he had only finished seventh grade, he was smart enough to become a machine operator. When the worker asked why he had not finished school, he told her that he had been brought to this country when he was ten years old and had had no formal schooling in the country of his birth. He added that his father had left his mother "in the old country." He said that he had been working without the necessary papers in poorly paying jobs. When the medical social worker asked him why it had been necessary for him to go to work he told this story too well, and with too little feeling: "You know how foreign fathers are. They expect you to work for a living. They don't put up with any nonsense. I don't know what my father will do when he finds out I can't work." The medical social worker explained that some one

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might be able to help his father see the value in medical care and that she would ask a public health nurse to call on him. She wrote a note to the father, advising him that a nurse from the health department would call on him and talk with him about where this care could be secured. The medical social worker showed Sam the letter and told him that she hoped it would be possible for him to have the necessary medical care, now, before his knee caused him further difficulty. Sam bid her goodbye in a less hasty fashion than he had originally planned his exit.

The medical social work consultant realized that he would need a great deal of help over a long period of time and discussed the situation with the public health nurse taking responsibility for further follow-up. The nurse was able to persuade the boy and his father to accept further medical attention and Sam was hospitalized. It was found that he had tuberculosis of the knee. The medical social worker at the hospital took an immediate interest in Sam, and kept in close touch with the physician in charge of his case. The end result, in brief, was that Sam not only completed necessary medical care but also accepted the idea that it would be well to secure vocational guidance and training. He eventually received his vocational training in a voluntary rehabilitation center where he could complete eighth grade work at the same time.

This illustration shows something else besides a medical social consultation service. It is a good example of team work. Here is a boy who came to an agency for a specific purpose, to secure a signature on a piece of paper which would make it possible for him to earn \$50 a week. That was all he wanted, at the moment, and he did not react very pleasantly to being denied that signature. The orthopedic specialist recognized this boy's immediate need for help in making further plans for his care. He did not take the attitude that his responsibility ended when he failed to sign the paper and explained why he could not do so. Sam's behavior toward those who offered help was understood as a symptom of his personal difficulties rather than as an affront to the workers concerned.

Perhaps it would be hard for some to see just how the medical social work consultant got clues to Sam's difficulties. The boy's manner did not give the impression he was cowed by his father. While in clinic he was abrupt, curt and impatient. He gave a very glib explanation of why he had to work for a living

by contrast both to his good appearance and his overly-independent manner. From her training and experience, she could put two and two together rather rapidly, and she recognized that this was far more likely to be a boy who was attempting to make up to himself, through work, for the deficiencies in his personal life.

It is not as easy as it looks, to come to all these conclusions in one interview. It was no doubt of real help to the public health nurse to have the comments of the medical social work consultant before she made the visit to the father. As the reader may suspect by now, the father was not what Sam depicted him to be. Rather, he was a gentle, pathetic, elderly man who admitted having lost a close relationship with his son, and who was grateful for any help which might be available. The effort that was made, all the way along the line, to show Sam that others had his future well-being in mind, that they took a personal interest in him, and that there were resources in the community which could be used to his advantage, made it possible for Sam to take care of first things first. In the process, Sam gained in many other ways—he not only had adequate medical care, but he also was trained for an occupation in which he could earn a good living and, at the same time, avoid undue strain on his knee. The job itself should provide more possibilities for a satisfying life than a highly paid, temporary, unskilled one. He made friends during his training, and the entire experience gave him a greater feeling of belonging in the country of which he had become a part such a few years before.

In reading about Sam, some may wonder where all the money came from to take care of his particular situation. As was mentioned earlier, in rural as well as urban communities, medical, social and vocational organizations are maintained through both public and voluntary funds for the use of individuals who are unable to meet the cost of these services alone.

Where Funds and Services Come From

Since the following chapters refer to a variety of community agencies, the reader may desire more information regarding organized efforts through which services essential for complete rehabilitation are made available to individuals with physical impairments.

Maximum physical restoration is so essential to the final result that rehabilitation is increasingly considered as an extension of medical treatment. Everyone knows about hospitals, convalescent homes and sanatoria operated under public and voluntary auspices. Voluntary funds for support of these institutions come from a variety of sources such as, individual donations, endowments, community chests, religious organizations, contributions from fraternal organizations and other private groups. Public hospitals are of course supported by tax funds, federal, state or local.

Various private organizations carry on extensive services which contribute to the rehabilitation of individuals with physical impairments. The National Society for Crippled Children and Adults has stimulated the development of many voluntary state societies which in turn have organized county committees that promote understanding of the needs of the orthopedically handicapped and provide assistance to individuals. The National Foundation for Infantile Paralysis was organized in 1938 for the express purpose of leading, directing and unifying the fight on every phase of infantile paralysis. This foundation has stimulated the organization of local chapters throughout the country. Aid available through this organization includes assistance in payment of medical and hospital care for individuals, provision of equipment to hospitals and financing of training of physicians, nurses and other personnel in the care and treatment of infantile paralysis. The foundation also sponsors important research projects in this particular field.

Other national organizations with local chapters render important services in the field of rehabilitation, for example, the

American Hearing Society, the American Foundation for the Blind, the National Society for the Prevention of Blindness, the National Tuberculosis Association, the American Heart Association, the American Red Cross. Fraternal organizations have sponsored extensive programs. Catholic, Jewish and Protestant organizations support many agencies providing services to individuals who need help in rehabilitating themselves. Local groups operate a variety of services essential in a community program. Among these are such services as a public health nursing service, family and children's agencies, sheltered workshops, vocational guidance and placement services, recreational and camp facilities.

Rehabilitation centers are being developed in local communities along the lines of the Institute for Crippled and Disabled in New York City, the Rehabilitation Center in Cleveland, the Detroit League for the Handicapped, the Boston Community Workshop, the Community Workshops of Rhode Island Inc., the Altro Workshops in New York City, maintained by the Committee for the Care of the Jewish Tuberculous, as well as the one for the industrially disabled, sponsored by the Liberty Mutual Insurance Company. The Subcommittee on Civilian Rehabilitation Centers of the Baruch Committee on Physical Medicine has made available specific plans for establishment of such community rehabilitation centers.

As much as these voluntary sources have contributed in the way of providing services, they have not been sufficient to meet the needs of all individuals willing to use various services to rehabilitate themselves. Many of the leaders of these voluntary organizations have taken responsibility for bringing the problem of unmet needs to our federal and state governments. As a result, the Federal Security Agency of the United States Government provides grants-in-aid to states for two programs closely identified with rehabilitation of civilians with physical impairments—the vocational rehabilitation program and the crippled children's program. Disabled veterans, of course, have their special sources of help in the Veterans Administration and the American Red Cross.

Where Funds and Services Come From 13

Under Public Law 113, which was passed in 1943 and which extended provisions of the Vocational Rehabilitation Act of 1920, states utilize federal funds to aid them in carrying out a complete rehabilitation program for civilians of employable age who are vocationally handicapped because of permanent disabilities caused by accident, disease or congenital defects. Services are administered by the state divisions of vocational rehabilitation, functioning under state boards of vocational education, and the state agencies for the blind. All services are available which are necessary to render disabled individuals capable of engaging in remunerative employment or to better their employment possibilities. These include medical and surgical care, hospitalization, physical therapy, occupational therapy, speech therapy, drugs, prosthetic appliances, vocational counseling and training, maintenance during training if needed, and job placement. The Act provides services for the mentally disabled, as well as the physically disabled. Medical restoration is available to individuals whose disability is an employment handicap, is relatively stable and remediable by treatment. The emphasis in this program is upon reconstruction for employment.

The divisions of vocational rehabilitation purchase certain services from appropriate agencies and individuals in communities, such as medical care and training. Direct services, however, are also provided such as prevocational and vocational guidance through vocational counselors employed by the state agencies.

The Social Security Act, passed in 1935, authorizes an annual appropriation for grants to the states to help them extend and improve medical, surgical and other services for children who are crippled or who are suffering from conditions which lead to crippling. The plan for services, submitted annually by each official state agency * to the Chief of the Children's Bureau

* Official state agencies administering services for crippled children include 30 departments of health, ten departments of public welfare, five departments of education, five crippled children's commissions, and three state university medical schools or hospitals.

embodies the state's request for federal aid, explaining how the funds will be used. The Act specifies that state plans must provide for co-operation with medical, health, nursing and welfare groups and with any agency charged with administering the state laws providing for vocational rehabilitation of physically handicapped children. While there are variations in each state program, the common goal of all is to encourage early discovery, and secure maximum restoration, in the widest sense of the word, for children and young people under 21 years of age with certain physical impairments such as those due to club feet, hare-lip and cleft-palate, infections of bones and joints, poliomyelitis, cerebral palsy, severe burns, accidents, rheumatic fever and other conditions. Depending upon the community facilities, direct service may be provided by the state agency or payment for all or part of the costs of such care may be made to other agencies. Implicit in the basic legislation is a broad concept of medical care which combines treatment of both the physical handicap and unfavorable social influences which, together, determine the degree and duration of the handicap. Both the crippled children's and vocational rehabilitation agencies employ as consultants professional personnel from appropriate fields, such as medicine, nursing, medical social work, and psychology.

In addition to these special services, public assistance and child welfare agencies are located in the state departments of public welfare with branch offices on district, city and county levels. Again, the Federal Security Agency helps states to maintain these public services. One category of public assistance which will be mentioned later is Aid to Dependent Children, which makes it possible for the mother to remain at home and care for her children when the father has died or is physically or mentally incapacitated. State and local departments of welfare may also pay for such rehabilitation needs as medical care, appliances and other services, in addition to providing funds for daily living expenses, when these services cannot be provided through other existing public and voluntary sources.

Last but not least, our educational system may provide, both

on a local and a state level, for the special educational needs of children with physical impairments. This includes not only special classes and home instruction for children who are unable to participate in regular instruction in the class room because of the nature of their physical impairment, but also residential schools for deaf and blind children. Local branches of the state employment service may also include provisions for selective placement of persons with physical impairments.

To the uninitiated, this may seem to be a confused picture. However, voluntary and public agencies do make an effort to get together on both a national and local level. Federal agencies have agreements with each other and with national voluntary agencies, which are designed to eliminate duplication. There is also the National Council on Rehabilitation, organized for the sole purpose of bringing together public and voluntary as well as business and industrial representatives who are interested in the rehabilitation needs of the mentally and physically handicapped. Locally, public and voluntary agencies not only make agreements among themselves in regard to specific services but work together for common causes through the local welfare councils.

In considering the job of rehabilitation then, we see that it may often be a group project rather than a solo performance. Certainly, the individual with the impairment is the star in the show. Without the services which are made available through public and voluntary funds, however, his potentialities for a highly satisfactory performance may never be demonstrated. Services are provided by human beings and are used by other human beings. The more each of us who provides a service understands what rehabilitation means, the better able we shall be to participate in this group project when we are needed.

2

How Does He Feel About His Handicap?

Much of what is now inside a person was once outside.²

GORDON HAMILTON

Influence of Time in Life When Impairment Appears

How A GIVEN individual reacts to a permanent physical impairment which may change his plans for the future, modify the appearance of his body, require long or painful treatment, or restrict certain of his activities, is directly related to his life experiences. The time of life at which the physical impairment occurs is of great importance. If he is born with it, he does not have the shock of sudden loss of function or alteration in appearance. But, he and his parents have the additional struggle of overcoming their feelings of regret that he does not have a perfect body. If the physical impairment occurs early in childhood, he may have the advantage of not remembering too well what it was like to have complete command of his bodily functions, but his family's reactions to his becoming handicapped will have their influence on his adult life. Adolescence, a difficult period for any child, may heighten awareness of and give new meaning to physical impairment which requires skillful parental help if new problems are not to be created. To develop a physical impairment during adolescence is, in itself, an additional burden which may have future significance. All along the way, then, from infancy to young adulthood, the

personality which is being developed will influence the successful outcome in rehabilitation.

If the physical handicap occurs during young adulthood, middle-age, or old age, how the person meets it depends largely upon the kind of person he has become at the time his handicap is incurred. Maturity in adult life is, at best, difficult to define, and no individual is so perfect that he functions continually in this ideal state. "Perhaps certain characteristics of what we mean by the term 'maturity' might be stated roughly as those of a person in whom enjoyment of dependence or inordinate pride in independence are replaced by gratification of interdependence. He still has considerable need to depend on others, a need to be loved, and a need to be cared for at such times and in those areas of his life in which he is unable to care for himself. He has a need, also, to have an opportunity to care for himself and to contribute to the welfare of others. . . . It is the relatively secure adult with considerable strength and capacity for independence who becomes least anxious, least resentful and least humiliated when in the force of circumstances, he turns to others for help." ³

What Handicaps May Mean to Parents

To return to the child, it is not our purpose to discuss at length all the possibilities in parent-child relationships when an element of physical imperfection has been imposed. Physical imperfection means different things to different people. Parents, being people, will vary in their abilities to look upon their child who has a physical impairment as a human being who will eventually be able to make the most of the remainder of his capabilities.

On the same day, and in the same newspaper, separated only by a page, appeared the reports of how two sets of parents met their problems in dealing with congenital handicaps in their children. In one story, the parents had helped their 14-year-old daughter, who had been blind since birth, to learn how to roller skate, swim and ride a bicycle. They had encour-

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aged her to take advantage of the special school available in the community; she had graduated from eighth grade and was waiting to enter high school. They learned that eye specialists in a large medical center far from home were performing a new and very delicate operation (corneal transplant) and turned to the crippled children's division in their state for financial aid to make this opportunity possible for their daughter. In another city, a young and attractive mother strangled her 5-year-old daughter who was unable to walk because of congenital spastic paralysis. She could not bear the sight of her child pensively watching others at play.

We do not know the stories behind these two newspaper reports, but they present striking examples of two extremes: the parents who make every possible effort to help their children and those, who for one reason or another, find it impossible to cope with the situation.

Neither extent of educational advantages nor amount of social assets can save a parent from feelings of pity or remorse that his child has a physical impairment. How parents feel about their children is an emotional affair. What happens to them, emotionally, when their child is born with or acquires a physical impairment cannot be controlled either by intellect or good manners. The fear which is ever present in the atmosphere in any community during a poliomyelitis epidemic is sufficient to remind the reader what may be possible in the way of personal suffering when the threat becomes a reality. Some parents are able to overcome their remorse but others cannot do so without a great deal of help. How they feel affects the personality development of their child. His personality development influences his potentialities for a satisfying life as an adult.

Relatives and Friends May Make it Harder

It is not uncommon for one woman to comment about another whose child has some physical defect: "Poor thing, she never got over it." Such a remark has a double implication:

Relatives and Friends May Make it Harder 19

one, that the woman herself still feels badly about it; and two, that her friend pities her because her child is not perfect in body. Those who cannot overcome their own belief that the hands and feet, hearing and sight are superior to mind and spirit risk warping the lives of those around them who have a handicap. In the following situation we see the influence of a grandmother upon a child's attitude. In this particular case, the physical impairment as such was well corrected, but the risk of disability was grave.

Betty, almost five years old, was referred to a rehabilitation center by an orthopedist, following a corrective operation for a congenital deformity. He asked that his patient have physical therapy treatments in order to help her learn to walk with ease. This child responded very well to the treatments and soon walked well with only a slight limp. After a few months, the physical therapist noted, however, that she would sometimes limp markedly and complain of pain in her leg.

The private physician maintained his close supervision of the child and there were no physical reasons why the child should complain of pain. During the entire time the child was known to the center, the medical social worker in the rehabilitation center had been acquainted with the mother and had encouraged her to expect the child to take gradually the responsibility for picking up toys, dressing herself and carrying on other activities normally assumed by a five-year-old. Some of the following comments by the parents, in the course of the discussion of Betty's difficulties, are most revealing.

The mother stated that the grandmother had become the greatest source of difficulty although she recognized that she gave Betty a great deal of attention herself when she found that the child was "crippled." To quote the mother, "She (the grandmother) says Betty is being neglected in favor of her little sister. I am trying to make Betty think that she is pretty normal now, but my mother keeps telling her that she is a crippled child and can't do anything. Now, when I tell Betty to dress herself, or pick up something, she says, 'I'm crippled, I can't do that' and starts limping worse than ever and says her knee hurts her. Later, when playing, she forgets herself and walks very well." In another interview the mother stated, "She (the grandmother again) makes such remarks as 'I hope she doesn't grow up like this. If she does, how will she get along?' Then Betty takes it all in and capitalizes on it as it suits her fancy."

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The father made these comments, "Mother thinks both my wife and I favor Susie. Because Betty was ill, mother thinks she should be given more attention and care, but you can't single out one child for attention. We don't think any more of Susie than the other. I told her she was the one who was doing the favoring. She comes and takes Betty home with her for a little vacation and gives her everything she wants. When she comes to our house to visit, she brings just one gift—for Betty. She never pays any attention to the other child and she feels it very deeply. Betty always gets away with murder with her grandmother and she knows it. That little girl is also an agitator. When she is with the other children, there is nothing but crying and fighting—the two play quietly when they are alone. I think she's smart but she's an agitator. You can't get away from that. I know that little girl."

Being the oldest child, it would be expected that Betty would have her troubles (without a congenital deformity which provided a limp) taking on a baby sister and getting used to the idea that she was no longer an only child. Grandmother might still have "favored" her as a first grandchild. But, because of the congenital deformity, Betty at five had already learned how to use this handicap as a powerful weapon. Her parents were helped by the medical social worker to cope with the situation in the family group. Since the child would soon be able to go to school full time it was hoped that this, in itself, would prevent the grandmother from maintaining too close ties with the child. By talking it over, another very important matter was revealed; the child was not responsible for the situation. This lessened the parents' impatience and irritability when trying to offset the grandmother's influence.

Adolescent Troubles

We see in Sara, at 17 years of age, a full-blown ability to wield the power of her handicap within the family group. This attitude affected the opportunity for her to be considered for vocational guidance and training until such time as her problems could be overcome.

Sara, at 17, wore her hair pulled back in a severe knot, used no make-up of any kind, and wore dresses very similar to those

of her middle-aged mother. She walked with double leg braces and crutches in a way which suggested that every movement required almost superhuman effort. Sara had reached the age where she was a candidate for vocational guidance and training, and the orthopedist was considering, with the medical social worker, certain of the clinic patients who would make likely referrals.

When it was Sara's time for an examination, the orthopedist noted that she had grown quite overweight, and that she did not get around with her braces and crutches as well as she formerly had. He asked her about her activities at the present time. In a sad tone of voice Sara explained that she had not attended school for some time. She had dizzy spells and occasionally seemed to "faint away." She thought she was having trouble with her eyes, because she seemed unable to read print. (She wore glasses and had an eye examination about once a year.)

The orthopedist, on the basis of these remarks, thought it would be well for Sara to have a rather complete study before being referred to the vocational rehabilitation worker. He also asked the medical social worker to become acquainted with Sara and her parents to determine what other reasons there might be for Sara's present difficulties.

This, in brief, is the story. Sara had had poliomyelitis when she was about ten years of age, and had spent a number of years in the hospital. She was described by the nurses who knew her as having been a girl with an outgoing, lively personality. She was quite a favorite with the other children on the ward. Her parents were devoted to her, visited her often and brought her many little gifts to make her hospital experience even more satisfactory. She had learned to sew very well, and made attractive gift objects. The occupational therapist found that she had real skill in the use of her hands. The school teachers described her as being an excellent student with unusual ability in mathematics.

In talking with Sara's parents, the medical social worker learned that when Sara first went home, her father drove her back and forth to school and she seemed to be quite interested in taking part, where she could, in activities around the house. Her father had a chicken farm on the edge of town. In thinking about it, her mother recalled that she seemed to prefer being with the grown-ups rather than with her former friends. In fact, she got along much better with adults. They took her to church with them and to their social activities. Gradually, however, she began to drop first one interest and then another. She often did not feel well enough to go to school and eventually her father stopped taking her. Her older

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brother, who was married and had several children, no longer was able to come for Sunday and spend the day because the children were too noisy and Sara often became ill and had to go to bed while they were there. Her parents believed that Sara would need to be taken care of for the rest of her life, and were carefully managing their affairs in order to put as much cash as they could away for her.

During the course of the medical study, it was found that Sara was overweight because she overate and moved about so little.* She was given a weight-reducing diet. The eye examination revealed no changes in her eye condition. The psychologist found that Sara had superior intelligence, but said that she was indifferent in her response to test situations.

Sara had several interviews with the medical social worker and was able to express, quite freely, her intense resentment that she had become a "helpless cripple." One thing which was especially hard for her was that her brother had been able to marry, establish a home of his own and have children. As Sara talked about her feelings toward her brother, his wife, and his children, she began to see that, as she put it, she was being "spiteful." In discussing her social life, she was able to figure out that she had not tried to retain friends her own age, or fix her hair and use make-up because she could "never get a beau, get married or have children." The possibilities of using her talents and taking some kind of training which would equip her to work and be an active member of her community began to take hold. When she was interviewed by the vocational rehabilitation worker she was enthusiastic about training as a bookkeeper which would be useful to her in the immediate future. She thought she might go on with her studies, later, and perhaps become a certified public accountant.

Over a period of several months Sara definitely began to perk up. She had her hair "done," was using lipstick and had shopped for more youthful appearing clothes. She stuck to her diet and lost considerable weight. She overcame her inability to read print and studied hard. Sara had a goal toward which she could work. She began to sew again and made stuffed dolls for her nieces. It seemed rather nice to have a sister-in-law and nieces, after all. When she became a bookkeeper she would buy gifts for the children. She was beginning to believe that she could have quite a satisfactory life for herself, even though she might not marry and have a family of her own. Sara was on her way.

* Eating is, of course, one of the satisfactions in life. Sometimes people who do not have enough other pleasures overindulge in this one, to their disadvantage.

In Sara's situation there were many strengths because she had had ten years of active, happy living before she developed poliomyelitis. Her parents were intelligent, friendly people who loved both their children and wanted each of them to have as much from life as possible. Although Sara and her brother had their normal rivalry prior to Sara's illness, after Sara became a "victim of poliomyelitis" it was no longer permissible for him to fight openly with her. Sara, however, had given up so much and he had added so much to his life that it could be expected she would feel resentful toward him. She needed to express that resentment and work it out for herself. Returning to a farm, after a fairly long period of pleasant group living in the hospital was a drastic change. Comparing herself with active young people she had formerly known was painful, so she attached herself to her parents and their friends. Quite understandably she wanted to skip young adulthood and her parents, in their sympathy for her, made a place for her in their own social life. She thus avoided her former friends. Her brother, being part of the family, could not be dismissed so easily. He seemed to be an ever-present reminder of the youth she feared she could not experience. It is not difficult to see how Sara could agitate herself and, with a heavy farm meal churning in her stomach, feel physically uncomfortable. To appear to be faint or to give the impression of exhaustion required no other explanation for her kindly parents than that the children were too much for poor Sara.

Sara had a good start in the hospital. She left it fortified with additional skills in avocational interests. She had kept up with her school work. She had been taught to walk well with braces and crutches. She might have gone on, on her own initiative, and her family might have used the money they were putting aside for her "invalid state" to send her to college. One important point is that because her parents did not understand and because Sara did not know about the opportunities for vocational training long before the day arrived for her to fill out an application, she was rapidly deteriorating into an unhappy, difficult person. Or, to put it in the language which some

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members of her community no doubt used to describe her, she was becoming "a very unfortunate girl whose life had been ruined by an attack of poliomyelitis."

Having a goal in life which afforded the opportunity to compete with others of her own age as well as contribute toward the life of her community provided the incentive whereby Sara could begin to overcome her personal resentment for being deprived of the normal function of her legs.

Results of Too Much Family Help

Parents who have worked hard physically for an independent existence sometimes worry considerably about a child who is not physically strong because they do not know how he is to maintain himself as an independent adult. They may fear for his future and, in their way, attempt to make his childhood an ideally happy one in contrast to what they do for their other healthy children. Unfortunately pity and fear do not produce desirable end results, regardless of the good intentions of the person who is trying to be helpful.

When we do for others because we feel sorry for them we are likely to go out of our way to give them *things* and be over-attentive to their physical needs. After a while, we begin to look for appreciation. When we get more demands, and perhaps complaints about the service, we are likely to become annoyed and consider the person ungrateful and spoiled. It is sometimes difficult for us to see our responsibility for having brought about this kind of a response. We have given our all, to the best of our ability, and now we firmly expect the recipient of our gifts to begin to show some favorable results from our efforts.

Idamae, a small blonde girl, 17 years of age, reported to the hospital for her yearly check-up. She had been born with a deformity of one leg. This had been improved by surgery, but she wore a built-up shoe and walked with a limp. She hobbled around, leaning heavily on the arm of her mother.

The mother, a plump, friendly, middle-aged woman, asked the

orthopedist if Idamae couldn't be readmitted to the hospital because she was "getting so ugly at home, we don't know what to do with her. She sits behind the stove all day and won't go to school any more." Upon referral to the social worker, the mother told the following story in a direct and uncomplicated fashion.

"For quite a while now, we can see that we haven't done exactly right by Idamae. Of course, she was the baby to begin with, and that makes it hard with a large family. I had no business having her—it's my fault. She's a lot younger than Jeanie and I was too old to have any more children (there were nine children each a little more than a year apart, and there was five years' difference between Idamae and Jeanie). When she came, she was crippled, the poor little thing. We all felt pretty bad about that. It was a terrible shock. There aren't any cripples in either side of our family. But then, we did our best. Maybe we did too much. We all felt so sorry for her. The other children went out of their way to look after her and keep her happy. They didn't mind if she got extras, because she was crippled."

Hitching the chair a little closer to the desk, the mother lowered her voice and said a little slower:

"But now—well, to tell the truth, everybody is just fed up with her. She's very ungrateful, I can tell you. She's deliberately mean too. A few years back the older children used to take her to everything that went on in the county, but she got so she would deliberately stall so they'd be late. She had to have so much help getting to the car from the house. Then, they just started going off without her. She's nasty to the girls who were in her class at school, too. They won't take the trouble to come all the way out to our farm just to have her insult them. My daughter, Isabel, says Ida has to be taken in hand by someone and made to change her ways. The married children say they won't take her in when we're dead, because she's so mean. What's to become of her?"

Through a plan which was carried out in co-operation with the orthopedist, the pediatrician, the psychiatrist, the child welfare worker and rehabilitation worker from the state bureau of vocational rehabilitation, Idamae came to live in a carefully selected foster home, near the hospital where she received physical therapy treatments which improved her gait. She had weekly interviews with the caseworker in which she brought out the picture of herself which was foremost in her mind—that of a deformed and hopeless cripple whom no one understood and no man would ever marry. The psychological examination revealed that she had superior intelligence, and the psychiatrist advised she had an "immature personality."

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Idamae remained in the foster home for almost a year and during that time she developed considerable initiative and learned to take more responsibility both for her appearance and her activities as well as sharing in family life. Some time before Idamae, herself, was ready to talk with the worker from the bureau of vocational rehabilitation, the medical social worker and the rehabilitation worker discussed her particular situation in detail. Idamae had had two years of high school and though nearing 18 years of age, it seemed best to encourage her to return to high school to complete the remaining two years. One sister lived in a college town. It was believed that if Idamae were willing, she might stay with that sister, attend a larger high school and have an opportunity to continue to practice her newly found independence and initiative for another year or two. If she carried through on this plan, and if she were interested, it might be possible for her to go on to college. If not, then some other kind of training, such as a business course, might be worked out.

In due time, Idamae began to develop an interest in what she would do when she was older. While she still thought it would be very nice to get married, in one of her interviews with the medical social worker, she said spontaneously that her chances for meeting a young man she would really like to live with for the rest of her life would probably be a good deal better if she were not searching in desperation. She had come to see that with an interesting occupation and the ability to earn a livelihood, her life would not necessarily differ from any other single woman who had not married because the "right man did not come along." She thought that she might like to be a librarian.

When Idamae was ready seriously to consider her own future, she had a conference with the rehabilitation worker. Idamae preferred to return to high school to complete the remaining two years, with the understanding that the rehabilitation worker would keep in touch with her and discuss the relative merits of library work or employment in business with her at a later date. After a discussion of further plans with the medical social worker, she chose to live with Isabel, and voluntarily agreed to do a certain amount of housework and give a certain number of hours to "sitting" with the children in exchange for her room and board. (Perhaps it is unnecessary to add that before this plan was definitely made, the mother, Isabel and the medical social worker had had a few conversations.) At the end of a year, she was making a satisfactory adjustment and had done well in her third year of high school.

Results of Too Little Family Interest 27

It is easily seen that this over-protected girl was not responsible for her state of immaturity or her overwhelming feelings of self-pity. It was a very painful experience for her to feel that her family were critical and unsympathetic. It was impossible for her to "grow up overnight," just because her family believed she had reached an age where she should exert some independence and show some initiative about her plans for the future. Growing up is normally a slow process, even under the most favorable circumstances. In Idamae's case, it was necessary to delay definite vocational plans to give her this opportunity.

Results of Too Little Family Interest

Not every parent is able to give his child with a physical impairment the kind of encouragement and help he needs in his struggles to meet his difficulties. Fortunately, children with uninterested parents often are able to find a relative, a family friend, a teacher, minister, community nurse, social worker, or some other adult who takes the interest in them which their parents are unable to show and, thus, are prevented from becoming embittered toward life.

Mable Adams was seen in a cardiac clinic at the age of 17 years. The medical history revealed that she had had three previous attacks of rheumatic fever, one at 14, one at 15 and another at 16 years of age. She had remained at home, during each attack, under the care of a private physician. As soon as she was permitted out of bed, she "ran wild" in the community, stayed out late at night, and her parents had "no control over her." With this history and these behavior difficulties the cardiac specialist advised the medical social worker and rehabilitation worker that her prognosis was guarded. Unless Mable's co-operation could be gained in leading a more regulated existence with adequate sleep, adequate meals, and moderate activity, she would, according to the physician, run the risk of having continued attacks of rheumatic fever until her heart was so badly damaged that she would be chronically ill.

Mable was the second oldest of eight children. When she first became ill, her mother was also ill with a cardiac condition. A visiting nurse in the community came in to provide bedside care,

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for both the mother and Mable. In retrospect, the father said he guessed it would have been better if he had "shipped them both off to the hospital." At the time, however, he saw no point in hospitalization. Mable was very unhappy about being restricted to bed, and as soon as she was allowed up and had her clothes on, out the door she went. She felt that her parents were not interested in her, and that as long as she had heart trouble, she might just as well be dead and out of her family's way. This disturbed girl was, in reality, acting out her wish to get ill again and "finish the job" by completely disregarding the doctor's recommendations. This struggle went on for four years. When she came to the attention of the clinic she was considered a poor risk for vocational training.

The medical social worker maintained her interest in Mable, providing the girl with the opportunity to talk with an understanding person in whom she could confide both her resentment against her parents and her worry about her heart. In a conference between the physician, medical social worker and vocational rehabilitation worker it seemed unwise to consider Mable for long-range vocational training at that time. She was too upset to be able to participate in such a plan. She was encouraged, however, to try sedentary work in order to earn some spending money and to occupy part of her time constructively. The rehabilitation worker found her a light bench job in a small factory.

As one might expect in this case, Mable changed jobs twice within the year, but she continued to show improvement in her behavior. By the end of the year, her physical condition had improved. The vocational rehabilitation worker agreed then that it would be a good time to offer her aptitude tests and consider possible long-range plans for her under these circumstances.

While Mable's resentment toward her parents' irritation with her and indifference toward her needs drove her to flaunt herself around the community in a socially unacceptable manner, William responded quite differently.

William was referred to the bureau of vocational rehabilitation by a pharmacist who employed him after school hours. The pharmacist had urged him to "try" this agency because the boy was very hard of hearing and he thought a hearing-aid might help him. The rehabilitation worker talked with the pharmacist about William and found that while he was a very conscientious, hard-working boy, he was difficult to get along with. He did not hear well but became angry when his employer wrote him notes. His employer understood that William was the son of a family who had lived in

the neighborhood for a number of years. They were hard-working, uneducated people, and it seemed to him that they had no appreciation of William's possibilities for the future.

William was trying to work his way through college, and, in his freshman year, he had secured a tuition scholarship on the basis of his high grades in high school. However, the pharmacist implied that his older brothers, who worked in a factory, thought of William as a "queer duck" for making so much effort to get an education.

The rehabilitation worker also consulted the university advisor who was interested in William and secured some of the same information as obtained from the pharmacist. William seemed brilliant, but he was often irritable and sullen when efforts were made to go over his class work with him.

After his first interview with the rehabilitation worker, arrangements were made for him to see the medical social work consultant. He talked with her about his loneliness, his fear of failure at the university, and his unsympathetic family. His parents felt he should learn a trade. William wanted to have some kind of a professional career. In addition to making it possible for William to see her from time to time, the medical social work consultant arranged for him to take lip reading at the American Hearing Society where he also participated in some of the social activities provided by the organization. Again, definite vocation guidance plans were not rushed. A good deal more had to be known about William's possibilities for improved social relationships.

William, born and raised in a large community, became hard of hearing at the age of 8 years but no lip reading was started until he went to high school. During high school, the amount of lip reading instruction was quite limited. He sat in the first row at school and somehow managed to get through high school with a high academic record. He had medical examinations from time to time, and attended first one clinic and then another. There was no known cure for his condition and a hearing aid was not recommended. He grew up, with the American Hearing Society just as available to him at 8 as at 18, a lonely, misunderstood boy, devoid of a satisfactory social life. Fortunately, through the interest of his employer, William finally got the help he needed. Through this help his personality difficulties may be overcome.

Other Children Can be Unkind

It would be quite unfair to leave the discussion of the meaning of a physical impairment to a child without pointing out that other children with whom they associate can be cruel. Their attitude also influences the behavior of the child with a physical impairment who is attempting to become a part of a group. Most often we are told that children with an impairment are mimicked. Sometimes treatment of the child with the impairment is even more unkind.

Jim was born with a spina bifida which was located high on the neck, rather than in the lower spine where it is usually found and is often concealed by the clothing. He had apparently enjoyed a happy and active elementary school life in the neighborhood in which his parents established a comfortable home. When he went to junior high school, however, the building was centrally located and many children from the various parts of the city attended.

Some of the boys that Jim had not grown up with seemed to think it was quite humorous that he had a balloon-like appendage hanging over the collar of his shirt. Liking it to a balloon, they enjoyed threatening him with pricks from needles and pins which they produced at odd moments. Jim's father was rather proud that his boy had not been raised to be a cry-baby, and Jim slugged it out after school hours with the pin-threateners. There were other effects than pugilistic activities. The boy became so disturbed that he could not concentrate on his school work. He was belligerent at home, and took to using profane language on a large scale.

Well-developed and healthy-appearing children who have cardiac conditions which are not discernible, have been known to suffer from what amounts to persecution in an effort to maintain their dignity and still not over-do, physically. It is very hard indeed, to be broad-shouldered, almost six feet tall, and to follow in the steps of two athletic brothers at high school, when one has serious cardiac damage which prevents him from participating in competitive sports. Being called "yellow" doesn't help, either. The bad temper which is vented on one's family and adult associates can be traced to this sort of torment, many times.

When An Adult Acquires a Handicap

Up to this point, we have emphasized what it means to the individual to have a physical impairment during childhood and adolescence. We have discussed the acquisition of a physical handicap by a person who has become accustomed to thinking of himself as physically normal. Loss of function of a part of our body, or actual removal of a part, is a disturbing experience for any person, regardless of how well he previously got along in life. John O'Hara, the 14-year-old boy mentioned in the first chapter, thought he was "too young to go without a leg."

If John O'Hara were to walk into a vocational rehabilitation agency at the age of 18 years, to have aptitude tests and to consider future training plans, he would no doubt impress the vocational rehabilitation worker as being a very satisfactory person with whom to work. He would be co-operative, would use his artificial limb well, and would be looking forward to whatever guidance the agency could give him. He would have overcome his fear of his inability to get along without a leg, and his resentment of curious interest or pity expressed by some of the people with whom he came in daily contact.

John O'Hara was helped to express these fears before his limb was removed, and was given encouragement along the way to use the limb, to return to his social activities and to go back to school. There was in his case prevention of the building up, in his own mind, of the idea that the adjustment before him would be a Herculean task. The child could see that he had something ahead of him. At 14 years of age it seemed to him that a grown man could make such an adjustment but not a boy. In our culture a man is idealized as strong and fearless. It is not easy, therefore, for a man or boy to admit his fears that he is less than a man in his ability to cope with his personal problems.

Robert Smith, 20 years old, reported to a bureau of vocational rehabilitation for consideration of training a few months after he had lost his right hand in an industrial accident. He had been working in an industrial plant while awaiting acceptance in the

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Air Corps. He seemed disturbed and confused and it was questionable whether he would accept help. For this reason he was asked to talk with the medical social work consultant before leaving.

He was described as a neatly dressed, intelligent appearing, attractive young man. He told the worker he came from a small town, that his father had always worked hard and had done what he could for his children. His mother died when he was small and an older sister took care of the house. He spoke in a straightforward and realistic fashion until he came to discuss the accident and the possibility of wearing an artificial arm. Then he could not go on coherently. Sometimes he cried, at others he became very angry, then despairing. According to Mr. Smith, his whole life plans were gone. On several occasions he remarked with intensity, "It should have been my head! I should have finished it! And it had to be my right hand!"

The medical social work consultant agreed with him that having his arm removed was a great loss. When he indicated that he would commit suicide, the worker asked if he really would do it. He said he guessed he was "too much of a coward" to carry it through. He was bitter that he would not be able to get into the Air Corps. Again, the social worker agreed that it was a real tragedy for him, but raised the question as to what he thought he would be able to do with what he had left—that is, his good intelligence—his former determination. Mr. Smith then told the social worker that he used to like to go places and meet people and after the accident he had worked as a salesman for a brief time. This job, he felt, was really very bad for him. He ran from town to town and his whole idea was to get away from people. He also said that his girl friend had stopped going with him. He would not discuss this further than to say "she couldn't take it." The medical social work consultant did not press him for an explanation but returned to the subject of his future possibilities. Mr. Smith again discussed his feelings of being very conspicuous and his resentment of curiosity and pity on the part of others.

After reviewing with him the fact that there would always be some people wherever he went who would be curious, he indicated that he thought he could become accustomed to it. He guessed it would make him feel better if he knew more about what he might be able to do, now that he no longer had the use of his right hand. The consultant showed him a book of illustrations of men doing skilled work with various types of artificial hands. At first his comments were, "Isn't this awful" and "Looks terrible" but then, he would look back at the pictures he had passed and remark enthusiastically, "See what they can do." He decided to return to complete

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the tests and secure vocational advice regarding future plans. He ended the interview by saying he did not know why he had told the worker so many things but "guessed it made him feel better."

Mr. Smith returned for further interviews with the rehabilitation worker and eventually completed the tests and accepted a position with an excellent beginning salary in a field in which he had had some previous training, a special interest and good possibilities for advancement.

In this particular case we see a young man who had attempted to solve his own problems by following the advice of friends and relatives, taking a job as a salesman (in which he was not actually interested) in order to force himself to meet new people and overcome his handicap. By the time he arrived at the bureau of vocational rehabilitation he still had the feeling that he *ought* to be "man enough" to work out the situation himself, knew he wasn't, felt very depressed, and could not decide whether he wanted to take advantage of the agency's services or not.

In one interview, the medical social worker was able to help Mr. Smith talk about the feelings he had tried to keep within himself. She reassured him that it was not only a great loss to him but that other people could be annoying through their pity and curiosity. Moreover, she helped him to understand that he could be expected to be upset about the matter, as any man would be. This cleared away one difficulty for him, and he could go on to think about "what he had left." Again, by implication (the pictures of the men using artificial arms) he saw that if other men had been upset, they eventually must have made an adjustment to their loss, or they would not have had their pictures taken using artificial arms. In that very short period of time he felt rather close to those men, because the medical social worker noticed afterwards that he had left his initials on the last page of the booklet.

The Disabled Serviceman Also Has Trouble

Much has been written, in the past few years, about the rehabilitation of the disabled serviceman. The kinds of difficulties

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which Robert Smith faced are common to the "hero" as well as the person who considers himself a "fool" because he caused his own injury through the violation of a safety rule. While the injured serviceman usually has had the opportunity for gradual conditioning he still has to work out the same problems. "Will I really be able to have as good a future as though my body were whole?" "Will my girl be 'nice to me' because she is sorry for me or does she really love me?" (More than one disabled serviceman has attempted to get rid of his girl in a hurry because he was no longer "whole.") They, too, have found it irritating and upsetting to be pitied, to be the object of curiosity.⁴ "When this man returns to his home community, he needs, above all, to be treated as a normal human being. Over-solicitude will undermine his hard-won independence. On the other hand, he will need patient understanding and encouragement to help him to adjust to his handicap and to civilian life. Learning to walk well with an artificial leg or acquiring dexterity with an artificial hand is not easy, and may require months of persistent application."⁵

Unfortunately, the adult civilian who develops a disability has not always had the opportunity to be hospitalized in a setting where he could be with many other persons with a similar condition. Few hospitals, at the present time, have anything which even approaches the extensive rehabilitation programs which were available to disabled servicemen and which have been added to hospitals for veterans. Why is this important? Because no so-called normal person takes lightly the loss of a limb or the disfunction of a part of his body. Because the individual who has previously made a good adjustment to life may build up fears during hospitalization and early convalescence which may later impede his satisfactory adjustment to his family and community.

The disabled serviceman was afforded opportunities for group living which provided healthy competition in the mastery of a disability, special equipment and programs carried on by experts. In addition, the need for the serviceman to work out some of his personal reactions to his handicap was recog-

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nized through the use of social casework services provided by the American Red Cross. The disabled serviceman who was so disturbed that he could not respond to casework help also had available to him psychiatric treatment within the medical organization of the military service.

A 21-year-old seaman was hospitalized for third-degree burns of the legs and thighs which he incurred when the furnace he was tending aboard ship accidentally exploded. Despite the sympathetic and careful approach of the medical staff, he was extremely fearful and resistant to change of dressings. At other times, he was jumpy, irritable, and complained and whined constantly. Because of his behavior, his fellow patients (who had had similar injuries) taunted him and called him a baby.

The plastic surgeon referred him to the social worker in the hope that she could help him to accept treatment more calmly and become better adjusted to his condition. The plastic surgeon was concerned, not only because of the seaman's outward behavior, but because he saw that it was affecting his general physical condition. He slept little, had no appetite and smoked incessantly. Eventually he would require a plastic operation and needed to be in good general condition before this took place.

When the social worker visited the patient, he met her interest in him with indifference. He lay there, gaunt and emaciated, staring at his burned legs. She returned several times before he felt he knew her well enough to hesitantly ask whether he could talk with her confidentially. Then he wept, shamefacedly, and said that he lay awake at night, crying and wishing he were dead. He realized that his behavior was less "manly" than that of his fellow ward-mates, and he wanted very much to be able to "take it" as they did. At the same time, he was so afraid he would not get well and so lonesome for his mother he seemed to have lost his emotional control. He could not write his mother while he was in such a turmoil, because he knew she would be upset and would come immediately to see him in the hospital. Then, if that happened, he was afraid he would act even more like a baby in the presence of other men on the ward.

The patient and the social worker had frequent interviews, after this, and he talked freely about his feelings of self-pity and his need to see his mother. Eventually, he was able to write his parents the kind of a letter which would set the stage for their visit. When the parents came, the social worker talked with them and helped them to plan their visits so that they would not be more frequent than

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those of the other men on the ward. She also talked with them about the kind of letters they could write him. Knowing what some of his struggles were, they would then not unwittingly discourage his efforts to approach his problem in a more adult manner.

The medical and nursing staff also found the social worker's evaluation of the patient's difficulties helpful to them in their work with him. The recreational worker was kept informed, too. Thus, as the seaman was able to become more a part of the group and accepted help of the recreational worker, he had less need for the casework service being given by the social worker. He slowly became able to do more for himself and to take responsibility for his personal care.

After many months of hospitalization, he had his plastic surgery operation and began to learn how to walk again. As would be expected, he had gained both physical and emotional improvement and the social worker was able to discontinue her services to him.

Sometimes the Effort Seems Useless

Circumstances may be such that the person with one or more permanent physical impairments actually reaches the point of view that life is so intolerable and unnecessary that it is best to make an attempt to end it.

While on the hospital ward awaiting a second eye operation, Miss Dana attempted to commit suicide by jumping out of the window. She was caught in time. The social worker was asked to talk with her to determine whether or not she could be of help. This was the beginning of five years of sustained interest and casework service.

When the social worker became acquainted with Miss Dana she found her to be an extremely shy, timid, depressed person who was surprised that anyone would have a sincere interest in her personal difficulties.

Miss Dana was described as a tall, thin, unattractive woman. She was wearing glasses and a black patch well concealed the empty socket where one eye had previously been removed. There was a cataract in the remaining eye and she had very little vision. In addition, she was under medical treatment for both rheumatic heart disease and osteo-arthritis of the spine. She impressed the medical social worker as being fairly intelligent and very conscious of her poor physical appearance. She said she had a married sister with whom she lived, and felt it would have been a kindness to her

sister if she could have been permitted to complete her suicide plans.

As the medical social worker became acquainted with Miss Dana she was able to help her understand that she was not interested in her out of pity, but rather that she would like to try to help her use what abilities she had toward a more satisfactory life. Miss Dana said she was so unattractive that she seldom went anywhere and had no really close friends. She had spent some time in bed at home when "her heart bothered her." The situation was discussed with the physician who provided the general medical supervision and a short period of convalescent care was arranged which helped to improve her physical condition. The medical social worker also facilitated the early securing of both an artificial eye and an abdominal corset, which improved her appearance and added to her comfort.

The medical social worker discussed the possibility that Miss Dana might accept aid from the division for the blind to pay her sister for room and board until such time as she would have an earning capacity. Miss Dana finally did apply for this assistance and found that she felt more comfortable living with her sister when she was not entirely dependent upon her financially. Later, when the physician found her physically ready to work part-time, the medical social worker arranged for Miss Dana to enroll in a sheltered workshop. Although she worked only a few hours a day, earning so small an amount as \$6 a week helped Miss Dana to feel like a more useful person and gave her added encouragement.

Over the years, Miss Dana steadily and slowly improved in social poise, appearance and in developing a more cheerful and outgoing personality. She continued to attend clinic regularly for medical supervision, and had regular interviews with the medical social worker. As would be expected, her general physical condition showed steady improvement. She was happier in her sister's home, no longer felt that she was a burden, and, through her activities at the sheltered workshop, she had made some real friends of her own.

Toward the end of this five years, Miss Dana came to the medical social worker saying that she was in "desperate need of advice." Since the sheltered workshop was part of a large agency which also provided recreational activities, at one of the social functions she had met a young man who was totally blind. He was regularly employed and earned sufficient money to support a wife. He wanted to marry Miss Dana and she seemed very fond of him. However, she was afraid to embark on this venture because of her great fear of their becoming dependent upon relief if he lost his job. After discussing all the assets and liabilities in such a mar-

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riage, Miss Dana finally decided to go ahead with it. Later, the medical social worker learned that the couple had made a very satisfactory adjustment to the marriage.

Miss Dana being the "shy quiet type" gave the impression to those around her that she was passively accepting her lot in life. When in the hospital on previous occasions for the eye operations, she was an unobtrusive patient. Her sister visited, she told no one of her problems, and no one bothered her. It was not until she was seriously depressed that she came to the attention of the medical social worker. By that time, there was nothing about herself, body, mind, or soul, which she felt was worth saving. The fact that she was capable of a life of real happiness would have seemed ridiculous to her at the time. Though the elements for satisfactory living were all there, what helped Miss Dana to overcome her feeling of worthlessness was sustained and constant encouragement, a step at a time, and the use of community resources which were available to her when she was ready to take the initiative in using them.

Miss Dana had first to see the value of herself, as a person, before she could take advantage of the opportunities which were available to her in the community. She had once earned her own living and looked after her own affairs. Somewhere along the line, however, the combination of her physical disabilities, her reactions to them and the attitude of others toward her, overpowered her desire to keep on breathing. It was known that she always had been a rather shy, retiring person even before her disabilities became too apparent.

The Need for Understanding and Help

In this chapter we have attempted to show by case illustrations various ways a person may react to his handicap and why he feels the way he does. All children, in order to grow up into mature adults, need not only affection and protection, but encouragement and praise in their efforts to show emotional and social growth in each stage of their development from infancy through adolescence. The parent is of vital importance, but he

is not totally responsible. Attitudes of other members of the family and community will also affect the ability of the child to take part in the social life around him. When a child with a physical impairment has had too many unsatisfactory experiences he can be expected to develop a less attractive personality than is ordinarily helpful to him as an adult. Then he is doubly handicapped. His response to those who are trying to work with him may not be co-operative. Unless he has help in overcoming his personal difficulties, he may not be able to use the services which would lead him nearer to a satisfying life.

As adults, we are what we have become as a result of our life experiences. Maturity is not an armor donned by the selected few who will, henceforth, be protected from any additional onslaughts. While it is ordinarily possible for most people who have met previous life experiences with proper fortitude to accept a physical impairment which they have acquired, none accomplishes it with a shrug of the shoulder. Some find it one blow more than they are able to take at the moment; others, because of their inability to cope satisfactorily with previous blows, crumple under the attack. Social casework services may be the method by which the person who is socially, as well as physically handicapped may overcome personal difficulties which interfere with his use of other rehabilitative services. This service may be required over a long or short period of time, depending upon the nature of his difficulties. The better those who work with persons with physical impairments understand the person with whom they are working, the greater is their opportunity for helping him, irrespective of the service which may be offered.

3

What Are His Future Possibilities?

It is written, That man shall not live by bread alone.

—LUKE 4:4

THE FUTURE possibilities of a person with a physical impairment are dependent upon a delicate balance between what he is, what he wants and what it is possible for him to be. Opportunities for the future, as they are apparent in the present, are influenced by factors other than an individual's desire to work and assume responsibilities befitting a mature adult. Among those which are outside his present control but which may affect employability are the extent and kind of his physical impairment, his previous education, his abilities and special aptitudes, his family responsibilities, his age and where he lives. All these are related both to training facilities and an employment market which will use his skills. Sometimes the outlook for the future is difficult to predict.

Is He Truly Unemployable?

The healthy young man who has lost a limb in an accident or as a war casualty does not present the same kind of a rehabilitation picture as the 38-year-old man with cardiac damage due to rheumatic fever.

Mr. Brooks had been known to the outpatient clinic of a hospital for a period of five years. He had been under the supervision of a cardiac specialist who had recommended bed rest at home, from time to time, when symptoms of recurrence of rheumatic fever

were present. At the time that the patient came to the attention of the medical social worker, the cardiologist advised that Mr. Brooks was able to do "light work" in a job where he would not be exposed to inclement weather.

The physician stated that when Mr. Brooks first registered in the clinic, examination of the heart revealed both aortic insufficiency and mitral stenosis. While the patient had marked cardiac pathology and should restrain his physical activities, it was his belief that selected employment would not be harmful and that Mr. Brooks might be able to work for a good many years if he took good care of himself.

According to Mr. Brooks' story he had made a good many attempts in the past to find satisfactory employment, but was rejected because of his cardiac condition. He had worked when he could, where he could, and when the work seemed more than he could manage he would stay home and rest. He seemed to feel that he was rejected by the bureau of vocational rehabilitation because his previous work history had been so sporadic. He was very discouraged because he considered himself useless to his wife and two growing children. Neither he nor his wife found it possible to accept public assistance as a permanent substitute for his earnings. Mr. Brooks believed that all his attempts to support his family had failed and that there was no hope for the future.

The medical social worker in the clinic referred his situation to a voluntary rehabilitation center in the community and Mr. Brooks was accepted there for a period of observation and consideration of possible training. The medical social worker had on previous occasions reviewed Mr. Brooks' physical condition with him and when the possibility of training was discussed with him she again brought out that there could be no definite assurance that he would secure permanent employment in the future. However, during the period of observation it was found that the rehabilitation center could offer him specific training which would equip him for skilled work commensurate with his aptitudes and in keeping with his physical restrictions. Mr. Brooks was so eager to become self-supporting that he completed the course in less than the usually required time. He was placed immediately and was able to support his family from his earnings.

One year later Mr. Brooks was still working, his physical condition was good and, needless to say, he was a very happy man.

While Mr. Brooks lived in a large city where there were both voluntary and public facilities available for vocational rehabili-

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tation, for one reason or another, the man and the resource did not get together for five years. He needed training if he was to work in a skilled occupation which could protect his health and at the same time provide a sufficient income for his family. It would be interesting to have more information concerning his difficulties in securing training through the bureau of vocational rehabilitation. If he had lived in a community where there was no other alternative, the medical social worker would have found it necessary to go into this matter. Perhaps she should have done so in any case. However, there are many reasons why a public agency may not have been able to offer service. One may have been that Mr. Brooks was not a good risk from a physical point of view, and the public agency may need to exercise caution in using tax funds for training where the long-range outcome is questionable. Voluntary agencies sometimes are in a position where they can experiment, so to speak, and build up a body of experience in a given area which may be useful later in determining expansion of public facilities. Thus, instead of duplicating each other's services, public and voluntary agencies, together, sometimes are able to provide the community with a much more comprehensive service than either could carry on alone.

The situation facing Mr. Brooks, who had a cardiac condition, was similar to that of a person who has had some other physical impairment resulting from an infection which can recur, such as tuberculosis, osteomyelitis or arthritis. Many times the actual progress of the disease process can be brought to a halt and the person may enjoy a fairly active and satisfying life if he is able to maintain a good state of physical and mental health. Physical over-exertion or fatigue brought on by worry and anxiety about the future will affect health and the infection will get the upper hand again. Over-work is bad; a depressed state of mind caused by profound discouragement over one's personal life is equally bad. Mr. Brooks could not find the kind of work which would protect his physical well-being and he could not tolerate staying at home receiving public assistance. He felt ashamed and inadequate as a husband and father.

A recently published book, *Health and Employment*,⁶ points up this dilemma clearly. Without training and selected job placement, some persons accept work which they will eventually be forced to give up because they do not have sufficient physical endurance to carry on. Others, because they are unable to secure suitable employment, may find it easier to accept public assistance if they think of themselves as too incapacitated to work. This kind of thinking may make it harder for them to rehabilitate themselves at a later date, when an opportunity for suitable employment may present itself. Obviously if a person is incapable of working, because of his physical condition, he should be helped to accept his situation as philosophically as he can. The problem is one of being certain that he is truly unemployable before we try to help him accept total incapacitation for work.

Shortsighted Thinking Versus Long-Range Planning

For a man with a family, the offer of specialized training requiring several months of reduced income, may seem like a luxury which he can ill afford at the moment. He may, on his own initiative secure employment which pays well and carry on until misfortune again overtakes him and he is forced to give up.

Seven years prior to his hospitalization for another illness, Mr. Williams lost a leg in an industrial accident. At that time he had four children under 7 years of age. He was referred to the bureau of vocational rehabilitation and, after careful consideration with him, the rehabilitation worker suggested training in office management rather than continuation in the kind of heavy industrial work which he had been doing prior to the accident. Mr. Williams was an intelligent, very responsible person who wanted to provide well for his family and give his children the education he had not had himself. The office management course seemed too long and drawn out for him, so he dropped it and went back to his former work. In addition, he worked irregularly in his spare time as a gas station attendant.

He was ill at home because of hypertension for almost four

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months before he sought admission in a large hospital in another state and during the time exhausted his savings. He had borrowed the money to pay for the hospital bill. After a few weeks observation and study, it was decided that Mr. Williams would benefit by operative procedures, to be performed in two stages, to reduce the hypertension. Even with such treatment and with good recovery, however, the physician advised that Mr. Williams would not be able to return to heavy work. Mr. Williams was to return home for a short period of time before surgery and, prior to his discharge, the physician referred him to the medical social worker for long-term planning.

Mr. Williams had many worries: his future hospital care, support of his family while he was incapacitated and his question as to whether or not he could take up the vocational training he had once discarded. The medical social worker planned with Mr. Williams regarding his use of the community agencies in his state. With his knowledge and consent, she wrote to the family welfare society in the city in which he lived, explaining Mr. Williams' medical situation and the medical plan. Upon his return home he discussed his family situation further with the caseworker in the family agency and also accepted temporary assistance. Later, he applied for a grant from Aid to Dependent Children. The social worker in the hospital also communicated with the bureau of vocational rehabilitation in his state. This agency accepted Mr. Williams as eligible for its services, including medical care. Responsibility for payment for hospitalization for remediable surgery was assumed because it was believed that the hypertension could be improved within a reasonable period of time. Without proper treatment, the hypertension would constitute an employment handicap.

Mr. Williams was reluctant to request financial assistance but he was also able to see that his two boys, then 13 and 14 years of age, might leave school as soon as possible to go to work if he did not make some other plan whereby the family could be financially maintained. The boys had already made some comments to this effect which also worried Mr. Williams because he wanted them to complete high school at least.

Arrangements for his medical care and family's financial aid were completed before Mr. Williams was re-admitted to the hospital. He said: "I feel as though a 500-pound weight had been lifted from my head." He made an excellent postoperative recovery which the physician attributed, in part, to social planning and relief from financial pressure.

While in the hospital for surgery, the social worker visited him

frequently. He talked about his plans for convalescence and later rehabilitation. He was able to discuss his own great "drive" to provide for his family. He spoke of his need to learn how to "slow down," which would require a good deal of thoughtful effort on his part. As he expressed it, "I will have to learn this just as I learned how to run a machine." He was able to see the wisdom of his wife's previous efforts to encourage him to take it easy. This attitude, on her part, had formerly irritated him, since his point of view had been that it was important to make every minute count.

While Mr. Williams was at home awaiting re-admission for surgery the worker from the bureau of vocational rehabilitation had talked with him on several occasions and assured him of the bureau's interest and desire to help him plan for training in office work. These preliminary discussions were of great importance to him because of his feeling of uncertainty as to whether he could have a second chance for retraining.

This case presents several danger spots, where, if there had been failure to understand Mr. Williams' needs, the outcome might have been less satisfactory. Mr. Williams entered the hospital as a patient from another state and paid his own bill. If the physician had not seen the patient's need for help, Mr. Williams and his family might not have made use of the facilities which were available to them in their own community. Mr. Williams himself did not know that the bureau of vocational rehabilitation might contribute toward the cost of rehospitalization for surgery. Considering that he was "ashamed of himself" because he had not taken their advice in the first place, he might not have been able to approach the bureau on his own initiative to inquire about either vocational training or payment for medical restoration. He might have borrowed the money, which would have increased his debt burden. Or, he might have returned home and to bed. His two sons were already concerned about their father's health and the family's finances. They might have left school as soon as possible to support the household even though this family was entitled to Aid for Dependent Children during the father's incapacitation. The rehabilitation worker might have considered as sufficient a notice to Mr. Williams that he could report to the agency for reconsideration after the physician found him ready for train-

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ing. An unintentionally brief and business-like letter might have made Mr. Williams feel that "reconsideration" was something quite remote and very questionable. Instead, the rehabilitation worker talked with him on several occasions. The teamwork demonstrated here cannot be underestimated in terms of the future for this man and his family.

When Should Family Responsibilities Come First?

While discussing family responsibilities, it may be of interest to bring out some points which may need consideration before encouraging mothers to think about vocational guidance, training and selective employment.

Mrs. Jones was a capable young woman faced with a serious problem. Her husband had an incurable illness and was not expected to live more than a few years. In addition, she had arthritis in the left knee joint. They had a lively three-year-old son.

In an effort to help Mr. Jones find some interesting activities to take his mind off his illness, the medical social worker at the hospital referred him to a rehabilitation center which operated a sheltered workshop. Mrs. Jones accompanied him to the center and discovered that it was possible to secure training in dress-making there. She already showed considerable ability along these lines and training would make it possible for her to secure good employment outside the home. Since she had a physical disability, she was eligible for consideration by the bureau of vocational rehabilitation.

The question was raised in a staff discussion as to whether or not Mrs. Jones should be encouraged to think about formal training and should have the possibilities for work opportunities explained to her. The medical social worker pointed out that Mrs. Jones had not expressed dissatisfaction in her role as a home-maker. The family were securing assistance from Aid to Dependent Children and Mrs. Jones was a good manager. The medical social worker further pointed out that if an effort were made to interest her in training at this particular time it might add an additional burden to her already complicated life. Should she leave her child and husband in the care of others while attempting training? Was it wrong to be willing to accept Aid to Dependent Children rather than to train herself to be able to support her family as soon as possible? It was realized that this woman might have felt an obliga-

tion to take training if initiative for consideration came from some one other than herself, but at the same time she was trying to learn an occupation she might have worried so much about her husband and child that she would not make the best use of the training. Therefore, it was agreed that Mrs. Jones would be given a general understanding of vocational training opportunities which might be available to her if she were interested later on when the child was older.

Mrs. Jones was potential material, so to speak, for vocational training, but the time was not ripe to stimulate her to use such services. Under a different set of circumstances, the decision might have been otherwise. Suppose that Mr. Jones' condition was such that he might live several years as a semi-invalid and that Mrs. Jones' mother lived with them. Mrs. Jones might have taken the initiative for requesting vocational guidance and training because she believed the solution to her family situation was full-time employment as soon as possible. She might, for example, believe that the little boy would be happier in a nursery school at least part of the day, and that she would be more companionable with her husband and child if they were not together all of their waking hours. Her mother might also see this as the best solution and be willing and able to take over household duties. In such an instance the harmony of the home might actually have been preserved by Mrs. Jones' employment in a skilled occupation with good earnings.

In other words, one mother may be better off at home, another in an occupation which utilizes her special aptitudes to a high degree. Such decisions must be made by the woman herself. It may be harmful both to the mother and the child to urge the mother to consider using her special aptitudes for future employment if she herself has not expressed a desire to do so.

Who Knows Best About Talents?

It is hazardous to assume that an individual who shows some special aptitude, but has a complicated physical impairment, can never hope to become even partially self-supporting. Under

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certain circumstances, failure to encourage such an individual to seek expert advice is a mistake.

A young woman who was severely handicapped by paralysis resulting from poliomyelitis spent several years in both a hospital and convalescent home. Her parents were prepared for her eventual return home and there was no difficulty in making this transition a pleasant one. The young woman had no power in her legs and very weak back muscles. The most satisfactory plan for her, from a medical point of view, was to get around in a wheel chair. She had a lovely singing voice which was considered by those who worked with her as a pleasant avocational interest which would be valuable to her in entertaining friends and relatives. She was referred to a voluntary agency which provided diversional activities in the home. As a gesture of appreciation, the young woman sang for the visitor from the agency. This visitor was so impressed with the quality of her voice that she discussed the matter with the agency's director. Arrangements were made for a voice teacher of unquestioned merit to visit the home for an audition. As a result, he has been giving her professional voice lessons in her own home without charge, and has agreed to attempt to launch her in a radio career when she is ready. Since she can be transported, she has already given a few recitals outside of her own home.

True, we must be careful not to build up unrealistic hopes in future possibilities for a person with a permanent impairment. However, it is better to prepare a person for possible disappointment than to deny him expert advice when his talents seem to be above the ordinary. The whole question of motivating the individual with a severe and permanent physical disability to think in terms of his future potentialities is one which must be carefully considered from many angles.

How Realistic Are His Hopes for the Future?

A disturbing example of extreme motivation of severely disabled persons to think in terms of future opportunities is sometimes noted most strikingly with those who have had cerebral palsy since birth. This condition is commonly described as spastic paralysis. The three main types of cerebral palsy are (1) spasticity, in which the muscles are stiff and tense, (2) athe-

tosis which is characterized by constant involuntary motion, and (3) ataxia which is a marked inability to balance the body as well as to co-ordinate motions. Athetosis and spasticity are the most numerous types of cerebral palsy, and spastic paralysis is said to constitute a little less than half the total. There are in the United States an estimated 70,000 children under 16 years of age affected by cerebral palsy who are believed to be educable. Cerebral palsy may affect speech, sight and hearing as well as control of bodily movements. The actual brain damage, slight or extensive, may not necessarily impair the thinking centers of the brain. Thus, it is possible for a person who is severely handicapped with jerking bodily movements, incoherent speech and drooling saliva, to have not only average but perhaps superior intelligence. It is estimated that only about one fourth of all persons with this kind of brain damage have intelligence at the feeble-minded level, or below. Of great importance is the established fact that the extent of actual physical disability is *not* necessarily related to lack of intellectual capacity.⁷

If the child with a severe type of cerebral palsy is to master the ordinary activities of life which we take for granted, such as walking, talking, feeding himself, taking care of his toilet habits, learning to read and write, he must not only have sufficient intelligence to co-operate in instructions but also an unusual amount of self-determination. If his intellectual capacities and self-motivation are encouraged in childhood, then he must have outlets for self-expression as an adult or he will be a very unhappy individual indeed.

Because of the very nature of the impairment, it is often difficult to evaluate all of the child's potentialities at an early age. When it is believed that he does have sufficient intelligence to respond to specialized training, then it is also necessary for his parents to take a realistic attitude toward that training. It is very hard for the parents. They may need help in order to understand that while training has improved the child's condition, he still cannot compete with others of his own age on an equal basis in all areas of activity.

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The following illustration tells how a director of a nursery school for children with cerebral palsy helped a mother see her child realistically. It needs no further comment.

Michael had severe cerebral palsy which markedly affected his speech as well as both extremities. Since infancy, he had been under expert care and showed considerable improvement, in light of the severity of his condition. At five years of age, however, he still could not carry on a conversation. He was a very bright, attractive child with a winning personality. His mother questioned continuation of intensive speech therapy because she felt that Michael really could talk, but that others could not understand him. Her theory was that as he conversed more, in a natural way, he would eventually be readily understood by others.

When the matter of speech training was discussed with the director of the school, the mother felt confident that Michael conversed with her. She said, "He asked me to take him to the ballet. I did, and he enjoyed it very much." When the director asked her to recall the exact conversation, the mother's version was something like this, "I showed him the advertisement on a billboard, and he said he would like to see that." (From her observations in the nursery school, the director believed that the mother raised questions and offered explanations to which the child responded by undistinguishable sounds and either a nod or shake of the head.) Realizing that the mother could not accept readily the fact that her child could not talk with others, the director used this plan.

Near the close of nursery school, she asked Michael to tell his mother to wait a moment, since she wanted to ride uptown with them in their car. Michael smiled happily, made sounds and nodded his head. When his mother came for him, he made sounds and waved his hands. His mother soothed him with "Yes, dear, I know you enjoy being here, but now it is time to go." Michael became more urgent in his sounds and gestures, and the mother began to question him. "Is your snowsuit too tight, dear?" and so forth. The director then walked up to her and gently placed her hand on the mother's arm, as she explained, "Michael is trying to give you my message. I asked him to tell you I would like to ride uptown in your car." The mother's face turned pale and her expression saddened. She took a deep breath as she replied, "I understand what you mean, now, about his not being able to talk."

At the present time there is growing professional and public concern for increased services and opportunities for children

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with cerebral palsy who have long been woefully neglected. Early and sustained treatment and specialized educational facilities will free many from what amounts to a virtual imprisonment of a normal mind within a hopelessly incompetent body. However, it is of vital importance to the prevention of emotional instability in the adult life of these children, that opportunities for creative activities and for actual work experience which are really commensurate with their total abilities be made available for them.

Stuart James, now in his early twenties, was born with severe cerebral palsy, affecting all extremities and his speech and sight. He was kept at home by his parents for a number of years, although some physicians who examined him thought he should be "institutionalized" as a "hopelessly defective child." When he was about 7 years old, the parents arranged for his admission to a private institution which has pioneered in specialized training for children with this condition. He remained for a few years, during which time it was estimated that he had superior intelligence, and he was well started on exercises and speech training. His mother was advised as to his mental capacities and her part in helping this child achieve greater independence. She worked very hard for many years to help him and the results were indeed gratifying. Stuart learned to walk quite well and take complete care of himself. At first he was tutored at home, but later he was able to attend special classes in the public school provided by his community. His speech was still a major problem, and he continued under the close supervision of a speech therapist. As the years went by, this boy gained the definite impression that, since he was so bright, he should not only go to college but he should choose a professional career of some kind. Stuart decided he would like to be a lawyer. Despite the years of speech training, this young man still makes marked facial grimaces when he talks and it is extremely difficult to understand him. Stuart wants not just to study law, he intends to practice it in the courts. He is angry, hurt and bewildered because persons interested in him do not believe he can achieve such a goal and are trying to direct his efforts elsewhere. He believes that if he tries hard enough he can do anything, and he intends to "hammer away at every law school in the country until he finds one which will give him his chance." His family can support him, so, as he says, "he will keep at it for the rest of his life."

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A different, but equally interesting case illustration of a young man of 21 years of age who had very scanty and inadequate treatment for cerebral palsy as a child, is presented as follows:

Arthur Short, applied for work at the United States Employment Service a few years after his family had moved to a large industrial center from a small town in another state. Since he could not fight in the war, he thought he should try to earn a living. However, because he had cerebral palsy with athetosis, a severe speech defect and had completed but sixth grade, the employment counselor suggested that he apply at the rehabilitation center for training rather than to try to find "just any kind of work."

Arthur's parents were separated and his mother was employed nights in a war plant at the time he registered with the center. Arthur assumed the responsibility for the housework and the supervision of a younger sister.

A study of this young man at the rehabilitation center revealed that while he had average intelligence, there would be great difficulty in giving him really comprehensive vocational training because he lacked basic academic skills and it would take him too many years to acquire them before more complicated training could be initiated. Arthur had a pleasing personality, was co-operative, and attended the center for almost two years. While there, he improved considerably in his actual bodily control and responded well to speech training (at the time he registered, his speech was unintelligible except to his family). He had learned to keep his arms down and take much larger steps although he is inclined to have a dancing manner to his walk. He spent a period of time in occupational therapy and work treatment shop, and the more interested he became in something outside the realm of housework the more bent he became on his idea that he wanted to be a mechanic.

From the beginning, the medical social worker had been interested in this boy, having frequently interviewed him at the center and visited the home to talk with his mother. The medical social worker gained the impression that Mrs. Short found the arrangement whereby Arthur did the housework and kept track of his adolescent sister a very satisfactory one. After he had been coming to the center a while he gained in self-confidence, began to make friends (since he could now converse with greater ease) and to do things in the evenings with other young people in his neighborhood. After a while he began to worry about his responsibilities at home. Arthur told the social worker that his mother worked hard,

nine hours a day, and it was difficult for her to carry all the household chores too. He thought he would be more satisfied to come just three days a week to the center. Again, because the possibilities for full, steady employment in private industry were extremely doubtful for this young man, the medical social worker did not discourage Arthur and his mother from working out this compromise.

Speech training was discontinued after two years because of his excellent improvement and his ability to apply the principles of speech which he had learned. Physical therapy was also discontinued, somewhat earlier, when Arthur had mastered necessary principles of relaxation and had succeeded in slowing down all movements. Arthur had sheltered workshop experience and it was the opinion of the staff that this type of placement would be the only permanent kind of employment which could be hoped for. However, as mentioned above, throughout the time he attended the center he expressed an interest in becoming a mechanic. His various capacities were carefully and repeatedly reviewed with him by the technical staff and, in his interviews with the medical social worker he discussed with her the difficulties of becoming a mechanic. The medical social worker, of course, throughout the entire period had frequent conferences with the physicians and technical staff and so understood his particular situation. His desire for some kind of employment in a garage remained very important to him and, finally, through family friends he was taken on as a helper. This despite the fact that previous staff conferences revealed that employment in a garage might constitute a hazard to this young man because of his imperfect co-ordination and the danger of slipping on a greasy garage floor.

At the time Arthur Short secured his job as a helper and on a few occasions during the months which he continued to attend the center for speech training, he talked with the medical social worker about the job in the garage. He was able to speak realistically about the fact that, during war time, it was easier to secure employment. The medical social worker encouraged him to think in terms of returning to the center to work in the shops when his present job ended. While, on the one hand, he could describe his real pleasure in being a part of garage life, handling tools and talking shop with mechanics, he was still able to say that this would not make him a "mechanic." He left the center feeling he had been helped a great deal there, could learn more and could even work there in the future if necessary.

The physicians and technical staff who studied Arthur Short's situation felt very definitely that if this young man could have

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had specialized physical therapy training, speech therapy and specialized educational facilities from early childhood to young adulthood he would have been able to take advantage of extensive vocational training and might have been employable in private industry. Since these opportunities had not existed for Arthur when he could best benefit from them, his future for employability in adult life was markedly restricted.

Both of these young men shared certain problems in common. Neither had had the kind of sustained specialized training which would have made it possible for them to reach maximum physical restoration. With Stuart James, he had had just enough to make his family realize that he needed constant encouragement to strive for greater independence. Stuart, however, had not been prepared to face adult life realistically. He was so disturbed by the results of the advice he sought, that one might wonder whether Stuart was trying to make others pay for his disillusionment. That is, because he had not been helped in childhood to see his limitations, his behavior might mean something like this: "You let me grow up believing I could do anything, and now I'll *make* you take what I can do least well." It is very unlikely that the little boy described in the nursery school illustration will be so unable to understand the place of speech in the community. With Arthur Short we can see that the awakening of his interests in the world outside his home was also accompanied by unrealistic desires, but at least he knows, intellectually, that they are unrealistic. Eventually, he may return to the sheltered workshop. Even though he said, "It makes me happy just to smell the garage," he may satisfy himself in years to come by friendly visiting at the garage. Some men enjoy stopping off at the city fire-station for a chat.

Value of Rehabilitation Centers and Sheltered Workshops

What Dr. Pattison has said of persons with tuberculosis might well be applied to others with severe physical impairments.

"The question as to the best method of helping them to return to a life of economic security, while still guarding against the danger of over-fatigue, unhealthful types of labor, unsanitary conditions in the workshop and the home and mental unrest has been most difficult to solve. Employment in sanatoria, farm colonies, and sheltered workshops has been tried for years with results of value." ⁸ It is true that strategically located rehabilitation centers and sheltered workshops will do much to help solve the problem for many persons with severe physical impairments. Many communities have no facilities of this kind, while others may have them only for people with certain impairments such as tuberculosis, loss of sight, or orthopedic and neurologic conditions. The Baruch Committee on Physical Medicine has studied this problem extensively and offers concrete suggestions, including building plans for such centers with dormitories attached. What has been learned through work with the tuberculous also raises another question. "If tuberculous patients could and would remain in sanatoria and be given the advantage of all known methods of treatment until they have reached the stage of so-called 'arrest,' the majority would probably remain well. But most of them won't stay that long, even if there were enough beds to hold them. They want to get out into the work-a-day world, earn a living and establish a home."⁹

Human beings sometimes find it hard, even under ideal circumstances, to live for long periods of time in an institutional environment. Though supervision may be as unobtrusive as possible, it still is not their own home. When there is a health basis, such as tuberculosis, they may be able to accept the need for such a plan for that reason. Some might not be able to accept permanent residence on the basis that the center is the nearest place to the spot called home where they can work. Rehabilitation centers and sheltered workshops are certainly desperately needed. Individual planning between the rehabilitation center and the community where the individual with the impairment has his roots will also continue to be necessary.

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The following situation seems to illustrate the problems which are possible when a combination such as age, kind of impairment and place of residence must be taken into consideration.

Mr. Harris, 61 years old, was hospitalized for treatment of ulcers of both legs. Shortly after his admission, the physician referred him to the medical social worker for after care planning, since it was not believed wise for the man to return to his former employment.

Mr. Harris had lived in this moderate-sized community for a number of years. He and his sickly wife occupied a fairly large walk-up apartment on the fourth floor which they looked upon as their permanent home. Mr. Harris worked as a combination elevator operator and janitor in an office building. He stood long hours operating the elevator, scrubbed down steps and hauled heavy trash cans to the alley. The physician's findings and recommendations were carefully reviewed with Mr. Harris and he seemed willing to undertake a change in occupation as well as to consider moving to a ground-floor apartment. However, over a period of several months, it was impossible to make the necessary changes in this man's environment which would have insured prevention of recurrence of the ulcers.

Mr. Harris had been referred to the bureau of vocational rehabilitation. He was found to be intelligent and responsible but it did not seem opportune in view of his age and general capacities to offer him extensive training for some kind of skilled work where he could remain seated. The employment service was unable to locate any kind of suitable work for him which did not require training. Mr. Harris, wishing to remain independent as long as possible, refused to apply for public assistance. He returned to his old job, but even though his employer removed certain heavy duties, the physician still believed the work was too strenuous. The only apartment which could be found in the community was a very small, two-room one on the ground floor in a housing project. The Harris's could not give up the "bric-a-brac" and other treasures they had accumulated over the years in order to fit themselves into the new apartment.

Mr. Harris will continue to carry on work which is too heavy for him, climb his four flights of stairs twice a day, and care for his ailing wife until such time as the ulcers break down again and he requires re-admission to the hospital. Either selective employment or a sheltered workshop might have solved a good

part of Mr. Harris' problem. He thoroughly understood the health hazards in continuing his present form of employment. Knowledge of the risk involved was not an acceptable reason, to him, for requesting public assistance at this time. His feeling might have been different if help had been available through insurance payments based on age or disability.

Some persons may be able to use a sheltered workshop and remain at home for a time even though the nature of their physical disability may eventually require institutional placement.

Miss Johnson, 29 years old, had a marked tremor of the left hand due to post-encephalitis. Since there was evidence of Parkinson's syndrome, a progressive neurologic disorder, the physician estimated her life expectancy to be that of another 20 to 25 years.

She was referred to the mental hygiene clinic at the hospital because of the mother's complaints that she was "unmanageable," and the mother's questions as to whether or not she ought to be sent to a mental institution. At the time of the study in mental hygiene clinic she was found to have "upper level feeble-minded intelligence." The psychiatrist, on interviewing both the mother and the young woman, noted indications of definite behavior difficulties but doubted that there was actual mental illness. He suggested to the medical social worker that this young woman might be safely employed as a ward helper in an institution for incurables, until such time as she, herself, became a patient.

In becoming better acquainted with both the mother and Miss Johnson, the medical social worker learned that Mrs. Johnson was very dominating and critical in her treatment of her daughter. The mother managed every detail of her life and gave her no opportunity for self-expression. As a result, when she "nagged" her to comb her hair, or help with the housework, Miss Johnson would become belligerent and even resort to striking her mother if sufficiently irritated.

After discussing the situation further with the physician in the medical clinic and the psychiatrist, the social worker inquired of the worker at the bureau of vocational rehabilitation whether Miss Johnson could be evaluated by that agency for possible training or selected job placement. The rehabilitation worker felt that the prognosis was too poor to consider the case, and the medical social worker then turned to a sheltered workshop in the community. Miss Johnson was accepted on a trial basis and not only made a

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satisfactory adjustment but was able to do simple clerical work for which she could be paid at the rate of 30¢ an hour.

During the next several months with help from the medical social worker, her difficulties at home were entirely overcome and Miss Johnson and her mother became so friendly she even used some of her earnings to treat her mother to the movies.

There is Always an Exception to Prove the Rule

It would not be right to leave this subject without giving consideration to the individual who, though disabled, may need or wish very little help in working out his own future.

Mr. Engle, a single, middle-aged man, had worked hard and earned an adequate living as a housepainter. For many years, he had occupied a ground-floor apartment in a building which housed several friends. He was admitted to the hospital for study and it was found that he had a chronic, progressive, circulatory condition known as Buerger's disease. At the time of his first admission, only one leg was affected, but the physician knew that eventually both legs would have to be amputated. The physician explained the medical situation to Mr. Engle telling him that amputations would be necessary to preserve his life. Of course he was concerned about loss of his limbs, but he was able to accept the physician's explanations and had confidence that this was the best possible medical plan for him. Shortly afterward, a friend visited him at the hospital. This friend was a dental mechanic who had a flourishing business. Since Mr. Engle had always been "handy with his hands," the friend suggested that he come to the shop as soon as he could get around on crutches. Even before the first artificial limb was ready, Mr. Engle was earning a living as an assistant to the dental mechanic.

When Mr. Engle returned to the hospital for the second amputation, he required a longer period away from work, while waiting for the stump to heal and learning to walk with two artificial limbs. The medical social worker was asked by the physician to plan for this period. It was very difficult, indeed, for Mr. Engle to accept the idea that he might need any help at all, except through personal friends. After skillful questioning the worker discovered that he had planned to use his small savings for a substantial deposit on the second artificial leg and that the remaining funds he had would not actually be enough to take care of his daily expenses. He had previously arranged for friends in the building to prepare and serve

his meals, but he was troubled by not seeing his way clear to paying them in advance for the cost of the food. He could not accept the idea that financial aid could be provided in the community both for the purchase of the limb and coverage of his daily expenses while he was incapacitated. To him this would be more humiliating than borrowing from friends. Since he was so unhappy about either prospect, the medical social worker suggested that he might wish to borrow necessary funds from the social service department. This arrangement, with the social service department purchasing the limb and loaning him a small amount of cash, seemed to be the most satisfactory one for him.

While at home, his dental mechanic friend set up a small work bench for him, and brought him some work every day. The hospital loaned him a wheel chair, and the friends in his building brought him his meals. He did his own housework from the wheel chair. When the second stump was healed, he went to the rehabilitation center for training in the use of the two limbs. In due time, he was back at the shop, earning \$40 a week. It should be unnecessary to add that he immediately started to pay back his debt to the social service department.

While it is obvious, in this illustration, that Mr. Engle was doing things the hard way, it still does not alter the circumstances of the case. Since Mr. Engle found it so very difficult to take help in managing his personal affairs, it was fortunate that he had friends who could supply him with suitable re-employment and help him care for himself during convalescence. No doubt this man would have stayed in the wheel chair and worked at home until he had the money saved for payment of the second artificial limb, if other funds had not been available for this purpose.

This chapter's case illustrations may possibly exasperate the reader. What is the answer to the problem of providing training and employment opportunities for persons with physical impairments where a combination of circumstances affect ready employability? That's just it, there is no quick solution, no magic formula. People are not all alike; illness and disability affect individuals differently. Some men will not be able to accept financial assistance as a substitute for work, because of the very real need they have for being considered adequate

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husbands and fathers. Others may be helped to accept such assistance because of what it may mean to their children later. In the rehabilitation of these men, aid through disability insurance might be an important factor.

Some handicapped persons will overaspire because they do not recognize their limitations along with their potentialities. Others will have potentialities which have been overlooked, because too much emphasis was placed on their limitations. Some will have a combination of needs which cannot be met unless the community is able to provide a specific kind of service, such as vocational training for selected employment, sheltered workshops and rehabilitation centers. Others may be able to solve their own re-employment needs through personal friends.

All we have for a measuring rod is careful physical, intellectual, social and emotional evaluation in relation to training and employment aptitudes and opportunities. The efforts being made at the present time to expand facilities for training and opportunities for work through public and voluntary agencies, as well as by industry itself, are indeed heartening. We might well close this discussion with the following quotation, "Rehabilitation is not a passive process which can be accomplished by any specific medicine or surgery or by any stereotyped training program. It is an active process which must be built around the needs and abilities of each individual and one in which he has the primary role." ¹⁰

4

Some Special Considerations in Success and Failure

*Before I built a wall I'd ask to know
What I was walling in or walling out,
And to whom I was like to give offence.*

—ROBERT FROST

THOSE OF US who offer organized rehabilitation services, of one kind or another, are sometimes baffled by the person with the impairment who seems unable to take hold of the service and use it to his best advantage. Sometimes there may be nothing which will work. Sometimes, when we ask to know what is being walled in or walled out, we find out more than makes us comfortable. We may see clearly and too well where one of the services, such as institutional care, helped to build the wall. Sometimes, in review, we wonder whether too much self-help might have been asked too soon of the person and his family in the light of the individual's impairment and life setting. In other instances, we see a combination of influences which makes us feel hopeless when we attempt to figure out how the wall might be broken down. This chapter, devoted as it is to success and failure, has been written in the hope that it will encourage thinking of failures as a means of preventing other failures.

Institutional care is day by day living. Many persons with physical impairments spend part of their lives in a hospital, convalescent home or sanatorium. That part becomes, for better or for worse, a life experience. Life experiences affect

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readiness to reach out for help in rehabilitating one's self. Many adults now trying to fit themselves for employment have been children in institutions. Others have spent the most recent years of their adult lives in institutional settings. While progress in medical and surgical treatment has shortened the length of stay considerably, persons suffering from serious spinal injuries, poliomyelitis, tuberculosis, osteomyelitis or rheumatic fever, for example, may still require institutional care for long periods.

It is true that long before the armed services of World War II set up the rehabilitation programs in hospitals for wounded servicemen, some tuberculosis sanatoria and certain hospitals and convalescent homes, especially those for children, made a serious and studied effort to maintain the kind of an institutional setting which would give consideration to the social and intellectual life of the patient as well as to his physical care. The wide-spread development, within the past 40 years, of provisions for social casework help in many medical institutions is also indicative of the effort made to recognize personal needs of the patients. Recreation, education, pre-vocational and vocational guidance and, in many instances, beginning of training for the job itself, mean much to a patient and should be brought to him as soon as he is ready for it. The needs of the individual who is acutely ill and recovers shortly may differ greatly from those of the individual who remains in the institution for a longer period of time. The purpose of this discussion is to show by case illustration what the provision of these services, or the disregard of them, may mean to the person who is theoretically on the inside for the purpose of getting ready to go outside. Hospital tradition holds that no hospital should turn a patient away without either giving care or helping him to get it elsewhere. If this holds before he is admitted, how grave are the responsibilities of the institution for helping him get ready to leave the institution after he has been under its care?

What Institutional Care May Mean to a Child

As far as atmosphere within the institution is concerned, there is something about the universal appeal of childhood, especially of the ill or disabled child, which seems to make it impossible to hold too rigidly to rules and regulations and pure white walls. Chicken every Sunday, ice cream twice a week, clean sheets every day, a clown to shake hands with personally now and then, the gay and warm and skillful nursing attention given when he is bathed or his hair is combed, the play lady, the teacher, the organized group activities—all these things are right, important and necessary. They may, however, represent a dramatic contrast to life in a child's own home. For many children, the period of hospitalization is short enough or their ties with their parents are strong enough that the marked differences in environmental advantages are outweighed by the disadvantages of separation from parents. However, some children remain so long in the institution and their family situation may be so unsatisfactory in all respects that the transition to home from the institution may be an unhappy and devastating experience for them.

Tom was in a children's institution for 10 years, for treatment of poliomyelitis. At 17, he became "overage" and efforts were then made to locate his family. It was discovered they had moved to another state several years previously. Tom had not seen them for a long time, and they did not correspond with him. He was sent home, however, even though his parents did not want him. When he arrived he found the resentment of his parents, the poor living conditions, the attitudes of his brothers and sisters more than he could accept. He became very critical and attempted to correct their ways. This was not appreciated and his family took him to a hospital in the hope they could get rid of him permanently.

Tom walked with double leg braces and crutches. He was handsome, well groomed and intelligent. The orthopedist believed he could perform restorative surgery which would make it possible for Tom to discard the braces and walk only with the aid of a cane. The operation was successful, but as the orthopedist said, the "case was a failure." Tom was so upset by his family situation that neither the sympathetic understanding of the hospital staff,

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casework help, psychiatric advice, the combined efforts of all with the staff of a rehabilitation center which taught him a skilled occupation could overcome his bitterness and cynicism. On his first job, he became the inside man for a robbery and was sent to a penitentiary.

The first institution where Tom had been a patient undoubtedly gave him the best of general physical care and, from his appearance, taught him manners befitting a select boy's school. An important omission, however, was the understanding of the gravity of their obligation when they took over the responsibility of his family for 10 years. Was the attitude of the institution in any way superior to that of his sadly underprivileged parents? After nurturing him for almost ten years, he was suddenly thrust out of the only home he knew. His family was expected to welcome him after having had no share in planning for him for almost ten years. Is it any wonder that Tom was resentful and revengeful toward society?

When a Child Cannot Go Home

Where there is an adequate medical social work staff in an institution, it is often possible for the social worker to help strengthen family ties where this is necessary. Since children with physical impairments come from all sorts of families, it follows that there may be some who are hospitalized by parents who do not want them and some who have no homes to which they can return. These children and young people have to be helped to find satisfactory substitutes. Depending upon their actual physical condition, it may be impossible to place them in foster homes as early as might be desirable. However, as the following patient said himself, one never knows until he tries. Myron Walsh spent 20 years of his life in a hospital and left it in a wheel chair. The circumstances of his preparation as well as his actual departure from the institution differed greatly from Tom's as did the outcome of the efforts which were made to help him become employed.

Myron Walsh was three years old when his parents brought him to the hospital because he complained of pain in his joints. He was admitted for treatment for a severe form of childhood arthritis which progressed, in spite of all efforts to combat it. After several years, the condition became static. Myron's elbows and knees were fixed in a slightly flexed position and he had limited use of his fingers due to the arthritic changes in his finger joints. He could get around only by using a wheel chair.

Shortly after Myron was hospitalized, his parents were killed in an automobile accident. No close relatives could be located. Myron grew up in the hospital, in every sense of the word. The personnel of the institution, especially the chief orthopedist and the supervising nurse, understood the responsibility they were assuming and gave Myron real affection and guidance. As soon as he was able, he was taught how to take complete care of himself, to get to and from the wheelchair and bed without help from others and was encouraged to take an active part in the life of the institution. He had such good ideas he was often given responsibilities for planning children's activities. In occupational therapy, he learned how to print signs very well and took charge of replenishing those which were needed around the hospital. He completed high school at the hospital and started in on university work through extension courses. As he grew older he was such an understanding person that the doctors and nurses encouraged him to take a special interest in some lonesome or frightened child, upon occasion.

One of the first referrals which the newly acquired medical social worker received came from the chief orthopedist and superintendent of nurses on behalf of Myron. Like parents, they trustingly asked for help. Myron could not remain indefinitely at the hospital. If he *must* go to a custodial institution, he probably could be prepared to accept the transfer. However, since he was such a fine young man and had contributed so much to the life around him, it was hard for them to believe that if the social worker concentrated her efforts on his problem she might not be able to think of some way of giving him a trial in the outside world.

When the medical social worker became acquainted with Myron, he spoke freely of the practical difficulties which would be involved in this trial. He had been taken on excursions from time to time by men who were interested in providing diversional activities at the hospital. He understood the difficulties in transportation. Myron said he had given considerable thought to what it would mean to leave his "home," and the two people who had been as parents to him. However, he wanted very much to try living in the community, though he realized that he might be unable to get

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along outside an institution. The medical social worker was convinced that Myron would make every effort to work things out for himself. The rehabilitation worker who often visited the hospital was inclined to think the plan a bit risky, but was willing to help. He found an old man who was running a haberdashery store which was on its last legs, and who would pay a small salary to someone who would sit in the store while he ran errands for his wife and had his lunch. He agreed that if that person could increase the business in any way, he could share in the profits. The place was in pretty poor shape and people had to look for what they wanted to buy. Myron was willing to try to help the old man bring order out of chaos.

Then there was the search for a place for Myron to live. The family welfare agency in the community literally turned the town upside down. Through a church, a middle-aged couple with two husky sons who had a car, were located. They were kindly folk, and the idea of boarding Myron appealed to them. Their sons did not find it too much of a burden to transport Myron back and forth to work. The family welfare agency paid the room and board at first.

Within less than a year, Myron had that business on a paying basis. He put the books in order, talked with salesmen who stopped by, and selected more appropriate stock. He was not only self-supporting, by then, but he had purchased himself an extra wheel chair which he kept at the store. Myron also continued his extension work at the university. Through his own efforts, a few years later, he secured a responsible position in a large organization's research department.

The medical social worker never felt that she had offered much casework help, as such, to Myron, since he was a well-adjusted, mature person. What she did was mobilize community facilities in his behalf. In all her years of experience she had never seen a more physically handicapped person who was less disabled.

After five years outside the institution, Myron was still doing very well for himself. However, we must recognize that some day he may have to enter a custodial institution. If that day comes he will no doubt be able to contribute much to the life of the institution if he is permitted the same opportunity for participation as was accorded him at the hospital.

When a Child and His Parents Are Strangers

Long time institutional care presents problems to parents as well as patients. Parents who are hard pressed to meet the demands of everyday living may come to think of the institution as the best place for the child. Over a period of time they may become aware of the many satisfactions that the child has in the institution and they may feel that they have little to offer him except their visits and occasional gifts. The special facilities and services of the institution may influence parents to feel inadequate to care for a physically impaired child. The child, because of his experience in the institution as compared with his memories of home, may come to the same conclusion. Thus, we may have the child resisting his return home and the parents not seeming eager to take him because both believe that he needs "very special care," which the home cannot provide.

Vera Roberts was admitted to the hospital at 14 years of age with a severe attack of poliomyelitis which caused extensive paralysis. Physical therapy treatments and skilled nursing care over an extended period of time produced excellent results. Vera was able to walk with only one leg brace after maximum treatment had been given. During the course of her hospitalization, Vera also developed another serious illness, an infection of the kidney which required its removal.

When Vera was 20 years old, she was referred to the social service department because the physician believed she was ready to leave the hospital and begin training for future employment. He advised the medical social worker that Vera's general health was good, despite the fact that one kidney had been removed. It was important, however, that she maintain this good state of health in order to avoid over-taxing the one remaining kidney.

The physician who had assumed major responsibility for Vera's care in the past seven years was very much interested in her. He described Vera as having a happy disposition and thought of her as a very intelligent girl who could probably be trained for a career along the lines of one of the arts since she had shown so much interest in painting, poetry and play writing. However, he was quite concerned about what would happen to Vera because of her family situation. It was his impression that her parents were dis-

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interested and he also feared they might exploit her when she was established in her future work.

The medical social worker found Vera to be attractive. She seemed relaxed and satisfied, surrounded by her plants, books and a radio. She showed the worker some of the correspondence which she carried on with former nurses and other persons who had been associated with the hospital. While she could walk with her brace, she said she preferred to use a wheel chair. She seemed to accept being taken care of as a natural part of her existence.

In talking with Vera, the medical social worker learned that she knew a good deal about what was going on at home. She said that she found it difficult to enjoy her family, however, since they were so "foreign." She did not think it would be possible for her to go home because her parents would not be able to "take care of her properly." She had a cousin, however, to whom she felt quite close. This cousin, she explained, was "intelligent" and taught school. By contrast, her sister had not had much education and Vera seemed to be ashamed of the fact that she worked in a restaurant. She thought it might be possible to live with the cousin because the house was larger, there were fewer people in the home, her cousin had a car and her aunt would give her good care.

In further interviews, the medical social worker also learned that Vera had the impression that she might be able to spend a good part of her time in the home of one of the nurses who had sometimes taken her to visit her family on weekends. The medical social worker talked with this nurse who said that she regretted that Vera had built up such an idea because she had tried to explain these visits as a special treat. The nurse also described the cousin as being a fine young woman and hoped that it would be possible for Vera to live with her. The nurse thought Vera was inclined to be "child-like," "self-pitying, at times," and required a great deal of attention.

It was further learned from the teacher and other nurses that Vera had had considerable help in her artistic projects and it no longer was so certain that she really had talent along these lines. The teacher indicated that she had been only a fair student and particularly disliked mathematics and history. Vocational aptitude tests did not reveal any special abilities and the psychological examination indicated that she had average intelligence.

The medical social worker visited the patient's family and found the parents, two sisters and three brothers occupying crowded quarters in a two-family frame building. The father was an unskilled laborer whose earnings were irregular, and the family income was supplemented by the sister's earnings. The father was

described as a small, nervous man. The mother appeared harassed and complained of asthma and headaches. The children, however, were in good health. The parents spoke of Vera with pride and looked upon her as quite a "lady." While they were willing to have her come home, they doubted that she wanted to live with them.

When the cousin was approached by the medical social worker, she said that she could not take any responsibility for Vera. The cousin and her mother both felt that Vera belonged in an institution where "everything could be done for her."

After considerable discussion between the physician, Vera, the medical social worker and the rehabilitation worker from the bureau of vocational rehabilitation, the best plan which seemed possible was that Vera should be sent to a nearby large city for training in office work at a rehabilitation center.

Her mother and sister accompanied Vera and the medical social worker to the city when she registered at the rehabilitation center. Arrangements had been made for Vera to board in a club maintained for young women where she would also have an opportunity to meet some students from other countries. This was a help to Vera in overcoming her belief that there was something wrong with having parents who were "foreign."

Vera was quite unhappy her first year at the center. She thought other students both "stupid and poor mannered," and she was not very enthusiastic about office training. She corresponded with the medical social worker and saw her from time to time, when she returned for medical check-ups and for Christmas and summer vacations. The second year at the center she made a much more satisfactory adjustment, and was discharged home, equipped for employment. She walked well with the brace, took complete care of herself, and had been trained to do typing, filing and switchboard work.

For the next three years Vera led a most unsatisfactory existence. She was placed for employment by the rehabilitation worker in the office of a man who, himself, had had poliomyelitis. However, she did not like her employer. He expected her to work too hard. He did not like her because he felt she "leaned on her limp." She left the job during a period of wide-spread unemployment and business depression and, like many others, was unable to get another job. During this time, she saw the medical social worker frequently and also wrote her letters. Vera often expressed her bitterness and disappointment because the medical social worker did not "rescue her," as she requested, and "find her a happier environment." She and her father quarreled frequently. The medical social worker allowed her to express her feelings of resentment and her dislike

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for her father, but at the same time tried to help her see what possibilities there were at hand for social outlets and job placement. Gradually Vera began to show more understanding of her father, grew more companionable with her mother and seemed to become more a part of the family. At the end of three years, she secured a position in a well-established organization. She was able to meet the requirements for this job and to hold it. Seven years later, she still had the position, enjoyed it, and seemed satisfied at home.

In this case we have an attractive, 20-year-old girl of average mentality who thought of herself as being in need of a good deal of physical care and who had vague ideas about a career in some branch of the arts. During the seven years she was in the hospital she grew away from her family and assumed that the interest of the physician and nurses meant that somehow they would provide a happy and satisfying future for her. She was in the hospital during her adolescence. It seems important to call attention to the fact that she might have had a hard time getting along with her father and might have been resentful of social deprivations in her home if she had gone on to high school instead of into the hospital. However, since there was no social service department at the hospital when Vera was first admitted, the estrangement between Vera and her family was increased by her long hospitalization. The delay in meeting Vera's personal difficulties no doubt made it harder for her to accept a completely different future than that which she had built up in her own imagination. Vera suffered much before she overcame her bitter disillusionment.

How Much Can We Expect of Parents

In going back and reviewing the life experiences of a person with a physical impairment we sometimes find that all of the necessary services were available, but they were not pulled together in the right way at the time the child needed them. Such an experience in childhood makes it harder for an individual to use services in later life. In the case of Charles, it was only the full understanding of his childhood problem which kept

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persons who were attempting to offer adult services from leaving him to his supposedly self-chosen fate.

In early adolescence, Charles attended a fourth of July celebration in which the "fireworks" included a loaded gun. In the hands of his inexperienced friend, the bullet lodged in Charles' spine. Charles was paralyzed from the waist down and had a loss of bowel and bladder control as a result of the injury. He spent 11 months in the hospital and was discharged to his parents after the medical social worker had evaluated home conditions. He was confined to a wheel chair.

Charles was the youngest child in a family of strong and active men. He was described as being very well built and good-looking. He had led a happy, active life prior to his accident. His parents were kind, intelligent, middle-aged persons who had provided their children with a comfortable home. All members of the family were ready and eager to help Charles lead as satisfying a life as possible. His brothers planned to take him on short recreational trips, to night ball games, etc. Charles lived in a large city where he could be transported back and forth to the special school. There were many opportunities there for him to continue his education and develop avocational interests. He could associate with other children who were learning to be more self-sufficient despite their disability.

Three years later, Charles was sitting in a chair, at home, staring out the window. He had but one pursuit—listening to "corny" radio programs. He would not go to school, would not return to clinic, would not let his brothers take him any place. In desperation, one of his brothers approached the rehabilitation center in that community to find out if anyone there might be willing to come to the home and talk with Charles.

As the three years were unraveled, it was learned that Charles was known to have been "depressed about his condition" when he left the hospital. However, it was apparently assumed that between his parents and the school, this would be overcome. The report from the school indicated that he was considered most "unco-operative." He continuously found fault with the program, despite the efforts made by the teachers and principal to interest him. He finally refused to permit the driver to carry him downstairs to the bus. A home teacher was supplied, but he asked her not to come any more, because "she didn't teach him anything."

When the worker from the rehabilitation center first visited, Charles was not interested in carrying on a conversation. He felt it

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was too much trouble for other people to carry him around. He had no future and others should not exert themselves or waste their time trying to interest him in school work, recreation or any kind of busy work. Nevertheless, the worker continued to make short visits. It was learned that Charles had formerly liked modeling with clay. The occupational therapist was sent to see him, and he was encouraged to try a bit of modeling. His figures were good and this led to some discussion of working with his hands, but care was taken not to give him the impression that he was an artist. Rather, his interest was directed toward seeking advice from a vocational guidance expert.

Eventually Charles agreed it would be well to return to the clinic for a complete re-examination, for recommendations for physical therapy (which were later carried out in the rehabilitation center) and for medical consideration of whether or not either appliances or further operative procedures would be beneficial. The specialists at the clinic, after careful consideration, decided that neither braces nor surgery would be of help in this patient's particular case. However, a urinal was recommended and Charles was instructed on how to regulate bowel movements, which added immeasurably to his personal comfort and lessened his embarrassment. In retrospect, it appeared that much of his difficulty earlier at school was related to his feeling about lack of bladder and bowel control.

Charles' interest in working with his hands having been aroused, and his return to clinic having brought some beneficial results, his next step was not quite so hard. He finally permitted his brothers to bring him to the rehabilitation center where he could have group occupational therapy and social activities. Later, he accepted a referral to the bureau of vocational rehabilitation. The rehabilitation worker found that he had unusual manual dexterity and suggested apprenticeship training in watch repair work. Charles accepted this idea, and was placed with a large firm. He applied himself enthusiastically to the training situation and finished the course.

One year after training, it was reported that Charles was earning \$45 a week doing watch repair work for this firm in a shop rigged up in his own home. He was making additional money from the watch repair jobs he took on for people in his neighborhood. He not only had been to a good many night ball games, but had gone on a short trip with his brothers.

This particular case illustration raises some thought-provoking questions. For example, if a urinal bag and regulation of

bowel control was possible three years after discharge from the hospital, might it not have been taken into consideration before the patient was discharged? How much did the diaper-like contraption which Charles had to wear to the special school affect this adolescent boy's attitude toward others trying to help him? There was one person, his mother, with whom he could feel comfortable about this kind of personal care. How much did he understand, while still in the hospital, about the possibilities for a satisfying future life which might be made available to him through community services which began with the special school, were carried through to vocational guidance and training and which, hopefully, might end in employment? In other words, how clear was it to this boy that while others would need to do some things for him (such as carrying him up and down stairs), there might be ways in which he could make some contribution in life which would make the carrying worth their effort? How well did his parents and brothers understand? The records do not show, but it seems reasonable to assume that emphasis might have been put on the taking-care-of angle to this family who were both sympathetic and eager to do things *for* Charles. The school personnel also tried to interest him, but how? Could it be that here again it was assumed that a group experience where other seriously impaired persons can be observed carrying out activities was enough? If the teacher seemed to associate some of Charles' difficulties with his humiliation over the loss of bowel and bladder control, might not consultation with the medical social worker at the hospital have been advisable before discontinuing bus service and sending in a home teacher? Is it possible that some of the people offering services to Charles lacked faith in the possibilities for successful rehabilitation of the severely impaired? Could they have felt it was a kindness to the parents and the boy not to build up any hopes for the future? Unfortunately, we sometimes feel that physical limitations are in themselves more hopeless than is actually the case.

If He Went to the Institution as an Adult

When an individual enters a hospital or sanatorium, he must be able to relinquish some of his independence if he is to respond satisfactorily to the medical treatment being recommended. He not only must have confidence in the physician but a willingness to accept life in the institution. This is particularly difficult for a competent man or woman accustomed to managing his own affairs and sometimes the solution is to "leave against advice." If a patient can temporarily relinquish independence to the point necessary for treatment, the period of dependence may be either a constructive or destructive one for him. He may leave the institution better equipped to lead a satisfying life which will, at the same time, protect his physical well-being, or he may leave it feeling as though he lacks much within himself to carry on satisfactorily in the adult world.

In many institutions there will be provisions for services in addition to medical treatment and nursing care, such as case-work services, occupational therapy, planned recreation, adult education, vocational guidance and training opportunities. It is then more likely that the individual can be helped to adjust to the long period of care and to prepare for his return to community life with a minimum of difficulty. The two case illustrations which follow, both of young single men with tuberculosis, point out what special services and after care planning may mean to the adult in the transition from present to future.

Adam Johns, a 26-year-old single man, was admitted to a sanatorium at a considerable distance from his own home. He had moderately advanced pulmonary tuberculosis and, prior to admission, had been ill at home for the past year. Mr. Johns had completed but two years of high school and had since had a number of jobs, the last one as an electrician in a shipyard. He was very anxious to get back to work, because he had formerly supported his parents. A number of years ago, his father lost a leg in an industrial accident and when the patient could no longer support them the parents had to apply for public assistance.

The medical findings indicated that Mr. Johns would need to

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remain several months on complete bed rest, his condition was classified as IIB, and his prognosis as fair. Pneumothorax treatment was also recommended.

The medical social worker became acquainted with Mr. Johns shortly after his admission. He talked with her about his family and she reassured him that his best service, to them, would be to remain until he was cured. She asked him about his interests and found that he had always wanted to be a writer. He said that he had been able to publish several nonfiction articles in children's magazines. He knew he could not return to "heavy work" but he was worried about what other vocational training opportunities might be open to him because of his limited high school training and his lack of English courses, etc. He was encouraged, early, to use the adult education services available at the sanatorium, and carried on a limited amount of studies while on bed rest. The medical social worker explained to him that as soon as he was permitted to be ambulatory, even for short periods of time, a worker from the bureau of vocational rehabilitation would see him and discuss with him in detail possibilities for his future training and employment. Due to pressures of work, the bureau in that locality was unable to accept referrals until patients were permitted to be up.

During the time he remained at bed rest, the medical social worker continued to see Mr. Johns frequently. Her comments are as follows: "Patient has frequently expressed a desire to leave the sanatorium, either to return to his parents' home or to secure employment here. Although he is intelligent and understands the need for treatment, he is anxious to begin to earn a living.—It is only as the result of interviews with the physician and the medical social worker that Mr. J. has been convinced he should remain in the sanatorium."

Later, when he was allowed out of bed, the vocational rehabilitation worker became acquainted with him. The patient and the vocational rehabilitation worker came to an agreement on a plan whereby Mr. Johns would enroll at a broadcast school where he could have training as a radio announcer and where there were possibilities for becoming a script-writer as well. The plan, of course, was one which also met with the physician's approval as being satisfactory from a physical point of view. The bureau of vocational rehabilitation provided a maintenance allowance and paid tuition and other expenses. The medical social worker helped Mr. Johns to use another community agency to locate a satisfactory place to live, and referred him to the tuberculosis association in the community for health supervision. Plans were so well co-ordinated

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between physician, medical social worker, patient and rehabilitation worker that arrangements had been made for him to register at the school the same day he left the sanatorium. At that time, he was permitted school work for four hours a day.

The sanatorium experience became, for this patient, a constructive one. When he left the institution his opportunities for leading a life more nearly to his own satisfaction were greater than when he entered. He had the services when he needed them. Efforts in his behalf were co-ordinated and directed toward one goal—his total rehabilitation.

Here is a somewhat different picture of another young man, Harry Paul, also single, who at the age of 33 years had been in and out of a given sanatorium for the past nine years. During the first six years of sanatorium care, he stayed intermittently with his father and stepmother who lived in a small community at not too great a distance from the sanatorium, returning for medical care when his condition became critical. After six years of this, he developed tuberculosis of the spine. For the next three years he remained consistently at the sanatorium except for the periods of time which he spent in the hospital in a nearby large city where a surgical collapse of the left lung was performed and where he had a fusion of the spine. He was discharged from the sanatorium wearing a back brace and was referred back to the hospital for orthopedic supervision. At the same time, he became known to the bureau of vocational rehabilitation. Since the hospital maintained a vocational guidance department which was used by the bureau of vocational rehabilitation for study of special cases, the rehabilitation worker asked that Mr. Paul also be given the opportunity for complete evaluation through this service.

Mr. Paul was described as being a large, clean-cut, neat-appearing man who seemed ill at ease and was greatly concerned about "improving himself." Prior to the time he developed tuberculosis he had worked on his uncle's farm. Since he could not return to farm labor, and since he had had little formal education, he was worried about his ability to succeed in some kind of work which did not require physical labor.

In the course of the interviews with the medical social worker

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in the clinic he talked about his experience in the sanatorium. "I did a great deal of thinking about myself—the doctors always told me not to think, but I couldn't help it. The more I thought, the more confused I became. I lost my self-respect, and it is hard to get it back. I felt like a numbered guinea pig in a hospital bed. If I had not had tuberculosis I would have been a good farmer and wouldn't have worried about not finishing school and making more of my life."

What bothered Mr. Paul most was that his father had wanted him to finish high school, but he would not listen to him. He had stepbrothers who had gone on to school and one of them was a successful salesman, earning a very good salary. Mr. Paul thought he ought to "prove his real worth to himself and then to the community." He thought he should take a salesman job which would require driving a car long distances and sleeping in hotels. The physician and the medical social worker reviewed with him, step by step, what the rigors of such a job would mean to him, physically, and he decided perhaps it would be best to try something with less spectacular opportunities for immediate success.

In the mean time, Mr. Paul completed his psychological and aptitude tests. He was found to have excellent clerical capacities and interests in business administration. With the approval of the physician, a plan was arranged between Mr. Paul and the vocational rehabilitation worker whereby Mr. Paul attended business school, starting with a few courses at a time. The bureau of vocational rehabilitation helped him to make arrangements to live near the school. Six months later, he was making good progress and his physical condition remained satisfactory. He seemed to be gradually getting over his feelings of personal inadequacy.

Mr. Paul, having had too much time to review his past, based his self-evaluation on his previous failures to utilize his life's opportunities. The more he thought about it, the more he blamed himself for his predicament and yet, as he put it, "If I had not had tuberculosis I would have been a good farmer." He could never quite decide whether it was his fault, or the fault of his disease that he felt so worthless. No doubt his concern about himself made his return to the community an even more fatiguing experience, to say nothing of the possible effect of such worry on his recovery while in the sanatorium.

In a recent newspaper article,¹¹ it was stated that around two-thirds of the patients now occupying beds in institutions for

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the treatment of tuberculosis were re-admitted following a relapse. In the same article, however, it was pointed out that of 512 persons who were followed over a period of five years by a county tuberculosis association, only five had relapsed. That organization had carried out a rehabilitation service which brought dramatic end results.

Is a Cash Settlement or Pension Always Enough?

Many persons who have industrial accidents or occupational diseases are first hospitalized before anything else is offered to them. Wounded servicemen who acquire permanent disabilities may spend long periods in the hospital, too. The difficulties of motivating a person with a physical impairment to think in terms of vocational aptitudes, training and employment, when he is receiving a disability pension were mentioned by Dr. Howard A. Rusk in his summary of the Veteran's Administration's educational and vocational programs now being initiated in hospitals for veterans: "There will be some, however, who are not concerned with getting well or becoming rehabilitated for fear of losing their monthly pensions, a fear springing from insecurity and anxiety.—That goal (of rehabilitation) can never be reached by the Veteran's Administration's rehabilitation program without a revision in existing pension policies which in some cases now serve as an economic crutch that prevents the functioning of the most important single factor in rehabilitation, the desire of the patient himself to resume the role of a self-sufficient, productive citizen."¹² The expansion of both psychiatric treatment facilities and medical social casework services in the veteran's hospitals bespeaks the willingness of the administration to look upon this problem of disability in the light of its meaning to the individual person with a physical impairment.

Study of the veteran's problem can supply much information and insight which is useful in treating patients who are compensation cases in civilian hospitals. Pensions and cash settlements are no doubt right and just, but it still remains that

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compensation in dollars and cents may not be enough. Payment of the doctor and medical bills by the insurance company is a great help to the individual; referrals to rehabilitation agencies upon discharge from the hospital also help those who are able to make use of such services. When indicated, psychiatric treatment and casework services while a patient is in the hospital might prevent needless suffering on the part of some patients and unnecessary sacrifices by their families.

Andrew Trask, 39 years old, burned both hands severely in an industrial accident. He was hospitalized for about a month in a private hospital, and when discharged, his physician sent him to a rehabilitation center for physical therapy treatments. Three months after the accident took place he was referred to the medical social worker by the physical therapist, because he was so upset about the condition of his hands and worried about his future.

The physician with whom the social worker talked before she saw Mr. Trask, felt that the patient was making good progress in the use of his hands. However, he doubted that this man could return to his former work after maximum treatment. The burns had been so severe and so extensive that the best that could be hoped for was good general use of the hands. The physician was also concerned about Mr. Trask's mental attitude and thought it would be helpful if he would consider vocational retraining possibilities.

Mr. Trask came twice for interviews with the medical social worker. He brought out his seriously disturbed feelings about the disfigurement and loss of dexterity caused by the burns. Mr. Trask had been a highly skilled craftsman who earned \$2 an hour at his work. He wanted his "old hands back." He did not want retraining. He wanted his "old job back." He called attention to the scars in a bitterly joking manner. He was receiving \$21 a week compensation from the insurance company, his wife had taken a full-time job, and his 15-year-old daughter was assuming certain household responsibilities after school instead of pursuing her previous avocational interests. Mr. Trask felt badly that his wife must go to work and his daughter deprive herself of pleasure, but this seemed to be the only way out because \$21 a week was not enough for their standard of living and debts were piling up. Mr. Trask's only solution was to secure a lawyer, through friends, who might be able to help him get a better settlement.

Mr. Trask was a formerly conscientious, highly skilled crafts-

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man. He showed real affection for his wife and daughter and was remorseful that, they too, must share the ill effects of the accident. But, a cash settlement or an increased pension from the insurance company would not heal Mr. Trask's emotional wounds. He had lost more than \$2 an hour in wages. He had lost the creative satisfaction which his highly skilled hands had brought into his life. He wanted his "old hands," his "old job," and no doubt, "his old self" back. What facilities had there been at the hospital, at the time of his admission, to recognize and help him in overcoming this real and profound loss? None. This man might have needed the services of a psychiatrist before he could have used casework help. Three months after the accident he had arrived at his own solution, an increased financial compensation.

Don Quixote Fighting Windmills

Pensions and cash settlements may mean more to some than they do to others. In the following illustration, however, one would be hard put to point to the \$21 a week and say that this, and this alone, is the reason why Stephen cannot rehabilitate himself.

Stephen fell off a truck and broke his back, injured his spinal cord, and was paralyzed from the waist down. He was also incontinent in bowel and bladder control. Prior to admission to X hospital he had spent several months at Y hospital. Altogether, he had had *16 months* of hospital care before he was referred to the medical social worker.

The referral was made by the student nurse who had been giving him bedside care because she thought some one ought to try to help him think in terms of his future.

The medical social worker, in becoming acquainted with Stephen and his family, learned that he was the only son of foreign-born parents. Both parents worked in order to pay for their home and supply their children with a higher standard of living than the father could provide as a plumber. They had wanted Stephen to complete high school, but he did not do well in school and left after about two years. He had had numerous unskilled jobs and spent most of his extra money on clothes and entertainment. He

paid room and board to his parents, however. His father was disappointed because he had expected his son to take advantage of the opportunities in this land of promise and become a personage of whom he could be proud. The accident and its end results was a great shock to the father. He felt, somehow, that between the hospital and the insurance company they would have to either make Stephen whole again or take care of him.

Stephen, himself, was content to remain in the hospital. He laughingly told an orderly that lying in bed, enjoying the radio he made as much money as the orderly. He hadn't given his future much thought, because he expected that he would remain in the hospital until he could "walk out under his own power," as he put it. He was not interested in talking with the worker from the bureau of vocational rehabilitation, because he thought he would rather be tutored to make up his high school work. In an attempt to get him started on a constructive activity, arrangements were made through the board of education for these services. He liked the teachers, and also seemed to enjoy occupational therapy services which were made available.

The medical social worker had a hard time trying to get into any discussion with Stephen about his future. To him, she apparently was quite far afield, since the insurance company was paying the hospital for keeping him there and he liked it. Around the Christmas holidays, an effort on the part of the physician and medical social worker to suggest that he go home for a while brought an immediate storm of protest from the father. The father could not be convinced that the insurance company had not put pressure on the hospital to discharge the boy.

Medical plans included another operation to reduce spasticity of the legs preparatory to fitting the braces, and so Stephen remained in the hospital over the holidays and had his operation later on. In due time, the braces were fitted and he began to learn to walk. About this time, the father refused to see the medical social worker. When the physician told him Stephen would be ready to go home soon, he became very angry. It was finally necessary to notify the insurance company that hospital care was no longer required. When this was done, the insurance representative notified the father and he came to the hospital to discuss discharge plans. As would be expected, he was extremely resentful and was convinced that the hospital was working in collusion with the insurance company. He took steps about the matter and wrote the state insurance commission. However, when this failed to get results, he agreed that he and his wife preferred taking Stephen home to making plans for his care elsewhere.

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The medical social worker had continued her interest during these months. She talked with Stephen and helped him to accept going home, but she felt that her efforts had not been very effective. Arrangements were made for the insurance company to pay for such additional equipment as the hospital bed and a special mattress. Stephen had been fitted with a urinal and had learned bowel regulation. A voluntary nursing agency providing specialized services for orthopedic patients assumed responsibility for home supervision. After several months, however, the father had still not built the inside railing on the stairs which would have made it possible for the nurse to teach Stephen how to get up and down stairs. The doctor, the nurse, and the medical social worker are still trying to encourage Stephen and to interpret to his parents the need for their help.

Perhaps Stephen's chances of successful rehabilitation would have been better if the referral to the medical social worker had been made soon after his admission to the hospital on the basis that here was a severely injured young man who would require considerable help in rehabilitating himself. At that time, the father might have been helped more effectively to bring out his disappointment in his son and begin to think of ways in which he could work with others to help this boy lead a meaningful life despite the impairment. Perhaps, too, if some of the other rehabilitation services previously mentioned had been offered to Stephen earlier in his institutional experience, he might have used them more readily. After 16 months of complete dependency, both the father and the boy had fully accepted this invalidism.

Our Responsibility to the Individual

The case material in this chapter seems to illustrate a few fundamental points which may influence success or failure in organized efforts to help individuals with permanent physical impairments. If an institution accepts responsibility for treating persons with physical impairments, does it not at the same time assume responsibility for helping them in the widest sense of the word? Recognition that the individual came from the

community and will return to it, for better or for worse, gives impetus to promotion of all services which will prepare him for his return as early as possible. Hand in hand with such preparation will go thoughtful consideration of length of actual hospital stay, essential for one individual as contrasted to another. Medical, nursing and social evaluation of the actual needs of the patients, as compared with his family situation and the community resources available, will be the joint basis for consideration of discharge plans. Discharge plans based on such limited factors as the age of the patient, his excessive demands for attention or the hospital's need for a bed will disappear. Timing of referrals to the medical social worker and the rehabilitation worker influence the effectiveness of the services which they may offer, just as delay in securing medical treatment affects physical restoration.

Prevention of disabling attitudes is a responsibility which should be assumed by every person offering any service. The school, like the medical institution, cannot always rely on group programs to touch off the spark of initiative or overcome personal difficulties. Sometimes an individual, personal problem interferes with group participation. When we "ask to know" we may see how a service other than ours may be used in behalf of the individual who does not respond. Each of us, in our own way, has a special contribution to make. None of us can make it in isolated splendor. Services can be correlated in such a way that each has meaning to the individual in terms of his future as well as immediate needs.

In our work with persons who have physical impairments, all of us might well keep this comment in mind. "Much work with the handicapped has been done with the self-conscious conviction that certain attitudes should be maintained by individuals who work with them. Long have we been aware that some handicapped persons have tended to become dependent. Our helping efforts have swung from the extreme of coddling and sympathy which weakens, to the discipline and denial which also may not strengthen. The decisive point is that those stock attitudes are not valid for general use. They meet the needs of

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some individuals but to the same degree frustrate others. We will help the handicapped individual only as we understand his needs as a person, not only the needs created by his handicap but also those which he has in common with other human beings." ¹³

5

Teamwork in Rehabilitation

Teamwork: Work done by a number of associates, usually each doing a clearly defined portion, but all subordinating personal prominence to the efficiency of the whole.

—WEBSTER'S NEW
INTERNATIONAL DICTIONARY

TEAMWORK in rehabilitation is created through the mutual understanding generated by two or more persons offering different, though related services to the individual with the physical impairment. This understanding stems from two sources: one, recognition of the particular area of competence for which training and experience has prepared the given expert to offer a specific rehabilitation service; and two, knowledge, understanding and appreciation of the value that services by other experts may have for the individual in terms of his total restoration. Teamwork is spontaneous under such circumstances. It can be enriched through patterns of working together, such as regular conferences, but it cannot be produced by virtue of the fact that various experts are housed under the same roof. Teamwork on behalf of individuals is often the dynamic force behind community planning. Thus, the joint efforts made to help individuals often spread outward to planning on a community-wide basis. In the preceding chapters we have attempted to show why social casework services may be needed by and be helpful to persons with physical impairments. In this chapter, we will discuss what co-operative effort, or lack of it, may mean in terms of helping the individual to make the best use he can

of his potentialities. Since the medical social worker is a participant in community planning, as well as one of the experts offering a direct service, teamwork will be discussed from both angles.

Immediate and Long-Range Teamwork

Teamwork is most easily demonstrated when the various professions are working together with an adult. This may take place between workers under one roof or between workers in organizations who have never seen each other. You will recall Mr. Williams who had the complicated operation to overcome high blood pressure and who had previously lost a limb in an industrial accident. His home was in one state, but he travelled to another state for his medical care. In this particular case, the physician and the medical social worker at the medical center participated in a team which included the rehabilitation worker and social caseworker in a family agency in another state. That team, like others working under the same roof, was able to be helpful to the individual because of their common understanding of his present and future needs.

Long-range teamwork can be demonstrated over a span of years, when the results of working with the physically handicapped child become obvious at the time he may request services from an adult organization. For example, John O'Hara, the 14-year-old boy who thought his active life would be over when his limb was removed, had the help of the medical social worker which he needed in order to prevent the development of disabling attitudes. Because he continued to grow socially, emotionally and intellectually, he would be expected to take hold of and use the services of an agency offering vocational guidance and training if this were necessary. By contrast, there was William, the young man who had been hard of hearing since childhood. He had been examined at several clinics during childhood and adolescence, but there is no evidence that help was given him or his parents in relating his particular physical impairment to his needs as a child or to his future. The school also failed to individualize this boy. He grew up

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socially as well as physically handicapped. His intellect, alone, could not make him a well-adjusted adult. When he reached an organized agency offering vocational guidance and training, this expert service had to be held in abeyance until it could be determined to what extent his personal difficulties could be overcome. Those who are working with the child and his parents are, in reality, members of the total team which help a given individual to make the best use of his abilities as an adult.

Many persons are helped to seek medical care, originally, through a community agency which has a continuing interest in them or their family unit, such as the public health, family or children's agencies, the school or the vocational rehabilitation service. Others need the resources supplied by other community agencies for themselves and for their families during the course of their treatment. It is not enough, then, that there be teamwork within any given organization. There must often be teamwork between representatives of various organizations. When the left hand does not know what the right hand is doing, teamwork is impossible.

What We Mean by the Leadership of the Physician

When the individual is under active medical care, we ordinarily speak of plans for his rehabilitation as being carried out under the leadership of the physician. This is of paramount importance because the physician is the only member of the team equipped by professional competence to make certain decisions. Only he can predict the physical effect of stresses and strains of given activities related to education, recreation, vocational training and employment. He does not, however, carry out such responsibilities in a vacuum. The interplay which takes place is exemplified in the case of Mr. Paul, who had been in and out of a sanatorium for nine years. In addition to having extensive, healed pulmonary tuberculosis, he also had tuberculosis of the spine which had been treated by surgery and he was wearing a back brace. In his interviews with the medical social

worker at the hospital where he was receiving orthopedic supervision, he revealed that he had an emotional reason for wanting to secure work as a travelling salesman. The reason was due to his feelings of inadequacy and his need to prove to himself that he could be as successful as his stepbrother, who was a travelling salesman. The physician no doubt found it easier to understand why this man required so much interpretation from him as to the physical hazards of such a job, because of the medical social worker's evaluation of the patient's problem. Through the physician's interpretation and the interviews with the medical social worker, Mr. Paul was able to come to the conclusion that in the long-run he would gain the most if he secured training which would protect his present improved state of health. He was then ready to accept help from the rehabilitation worker. Vocational evaluation indicated that he could be trained in business administration. The plan was considered suitable by the physician and it was acceptable to Mr. Paul.

While the first step in planning must always be the assessment by the physician of the patient's physical strength as well as limitations, that is but the first step. The social worker's assessment of the individual's ability to accept his limitations and thus his readiness to use the expert services required in vocational guidance, training and employment plans is the second step. It may be a waste of the time of the rehabilitation worker to send him a routine referral from the medical agency on the basis of medical findings alone. The responsibility for knowing which patients are emotionally ready for vocational rehabilitation services rests with the medical agency. It is that agency which is best suited to help the patient overcome the personal difficulties related to his physical impairment when he is under medical care.

The role of the medical social worker at this point is discussed in a recent publication of the United States Public Health Service.¹⁴

The decision as to vocational referral and the appropriate time for the referral are dependent on many factors

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which require joint consideration by the team. The medical social worker contributes in these ways:

1. She brings to the other members of the team the information which she has gained in her interviews with the patient regarding his background, his family, his attitude toward his disease, his previous work interests and achievements.

2. She is in a position to know which patients are ready, socially and emotionally, for vocational service. Some will be able to return to their former occupation; others may return to their households and assume these duties. Some in this group who are medically able to leave the sanatorium are not ready emotionally to accept the fact that they can return to their normal environment and to some type of occupation.

While the physician assumes leadership and makes the decisions which have a direct bearing upon activities of individuals, these decisions are not always accepted by the patient with good grace. He may interpret the physician's recommendation as an unsympathetic or unkind act. In this regard, one physician states: "The physician must be prepared not only for respect and admiration, but also for the negative and hostile feelings the patient may project on him."¹⁵ Another physician suggests that he should ask himself, "If I were the patient and had his personality how would I want to be treated?"¹⁶ Sam, the boy who sought approval of working papers and was angry when the physician told him he needed hospitalization instead, exemplifies the patient reacting unpleasantly to the physician's recommendation. Despite the boy's unfriendly attitude, the physician walked with him to the office of the medical social work consultant, as a sympathetic gesture, explaining on the way that he might like to talk it over before he left the clinic. The physician not only acted in his leadership capacity but, at the same time, passed on to another member of the team a responsibility which he rightfully considered hers. To quote again: "We expect her (the medical social worker) to use her

own special skills in enabling the patient to accept our interpretation of his medical problem and to take hold of the therapeutic program we are offering. We see her as having capacity for helping the patient to participate more fully and comfortably in the doctor-patient relationship and in the process of medical diagnosis and treatment." ¹⁷

The person under medical supervision who cannot follow out a plan which has been advised by the physician, either to increase or decrease his physical activity, has personal reasons for his behavior. Ideally, these difficulties will best be solved if recognized early in medical treatment. Mr. Brooks had been under medical supervision in a clinic for five years because of rheumatic fever which had resulted in permanent heart damage. He had been working "when he could and where he could" although the physician advised "light work where he would not be exposed to inclement weather." Mr. Brooks' need to work in order to be an adequate husband and father overshadowed his ability to accept the physician's advice. Intellectually, he grasped the physician's recommendations; emotionally, he could not accept financial aid as a substitute for his own earnings. In this instance where special arrangements were required because of his questionable prognosis for employability, the medical social worker continued her interest in the patient for a year after he had been employed. There was always the possibility that he might not be able to carry through to his goal. Then considerable casework skill would have been required to help him to see the value, for himself and his family, in accepting financial support. Prior to the physician's referral of this man to the medical social worker he carried out the physician's recommendations only when he became ill and was forced to go to bed.

The physician, with or without the aid of consultants, may make a fair shift to collect and interpret the biologic data, but in the hospital milieu the social worker, who sees the troubled, overanxious patient or his family group, and can relate herself to his home situation and responsibilities

with skill in discerning what social factors influence his illness, is indispensable in making an accurate, complete diagnosis. . . . It must include not only the disease but an understanding of the patient who has it. . . . When the diagnosis has been achieved, then treatment must be planned and carried out. . . . While the doctors are attending to the more strictly biologic aspects of a case, the social worker will be evaluating its social hazards. . . . Patients may be so overwhelmed by social problems which they cannot solve that it may be impossible to treat them successfully until these problems are solved.¹⁸

Teamwork and Continuity of Services

Timing the offer of an appropriate service is a vital factor in helping an individual to rehabilitate himself. With some patients, their personal resources (emotional, intellectual, social and financial) will be such that they can accept the physician's explanation of their needs, follow instructions, co-operate in necessary treatment, use information regarding vocational rehabilitation services and take the initiative for making an appointment with such an agency if the physician advises them to do so. Others, however, may find it difficult to carry out even the first step, that of medical treatment, which may be necessary before vocational rehabilitation services can be considered. The teamwork exemplified in the situation of Mr. Johns, the young man who had tuberculosis, who was worried about what he could do for a living because of his previous inadequate education, and who found it difficult to remain in the sanatorium, shows purposeful, related activity on the part of several experts. There were no gaps in continuity in all the services which he needed to restore him to satisfying adult life. When first admitted, his primary need was for medical and nursing care. The medical social worker was able to help him to accept first things first, but at the same time encouraged him to think in terms of future plans by explaining the other services such as adult education and vocational guidance and training which he

could use when physically ready for these pursuits. As his physical condition improved and as the physician was able to approve additional activities, the patient was prepared and ready to use other services. Through joint planning under the leadership of the physician, the physician, the medical social worker, rehabilitation worker and public health nurse in the community assured the patient of opportunity to continue in his efforts to rehabilitate himself under the most favorable circumstances possible upon discharge from the sanatorium. There is a plus factor to be considered in the timely offering of appropriate services to an individual. He may gain added strength to overcome his feelings of inadequacy and his fears for the future which, in turn, helps him to make the most effective use of the services available. Society has made help available to him because he is considered to have some value in society.

Lack of continuity and gaps in offering appropriate services may make it harder, if not impossible, for an individual to rehabilitate himself. There was Stephen, for example, who was hospitalized with a severed spinal cord and paralysis from the waist down for 16 months before medical social work services, occupational therapy and pre-vocational services were offered to him. Even though there has been considerable teamwork among the experts providing related services to this young man in the past year, the outcome still remains extremely doubtful. The time when these services might have had the greatest opportunity for acceptance by the patient and his family was early in hospitalization. One also wonders if it would have taken five years for Miss Dana, the woman who attempted suicide while in the hospital for another eye operation, to have developed satisfactory feelings of self-worth through medical social case-work service and the use of other community resources if her need had been recognized and services offered when she first attended clinic.

The earliest opportunity for helping the individual to use all the services he needs in order to rehabilitate himself very often occurs when he seeks and secures medical care. At that time he learns what is wrong and what can be done to correct

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or minimize the impairment. Whenever the physician and the patient consider what his impairment means in terms of his personal life, there is an opportunity to discover whether or not the individual has the personal resources to carry through on his total situation. Since a physical impairment, in itself, does not necessarily constitute a handicap in the life of every individual, there will be some persons with different kinds of impairments who can work out their own solution once their physical ailment has been diagnosed and treated. There is always the exception that proves the rule. You will remember Mr. Engle, the single, middle-aged man who had both legs amputated and who made his own plans for retraining and re-employment through personal friends. In many instances, however, the handicapped person will need the help of one or more services other than those which may be strictly defined as medical treatment. There will also be those who cannot accept needed medical treatment because of personal problems. If the physician has the services of a medical social worker available to him and his patient, the possibilities for helping the individual make long-range plans appropriate to his particular life situation as well as his physical condition will be that much greater. However, due to the pressure of work and the shortages of professional staff within medical institutions, it is inevitable that for some time to come we cannot hope to achieve the ideal state of affairs where personal resources will be a known entity, for every person who has any kind of a physical impairment.

The Medical Social Worker as a Part of the Team

Teamwork flourishes best when a recognized pattern of working together has been established between the various experts offering services. Since, in the medical setting, the physician is the leader of the team, the primary source of referrals to the medical social worker will be through him. The method most frequently used is that of the physician referring those individual patients whom he believes have personal and environ-

mental problems which are interfering with total restoration. Other members of the team and representatives of outside agencies also refer individual patients to the medical social worker but she does not offer service to the patient without first consulting the physician.

Another method which is sometimes used is that of requesting the medical social worker to interview all patients with a given condition, such as tuberculosis, rheumatic fever or poliomyelitis at the time of hospital or clinic admission. In this way, other members of the team are provided with an early picture of the patient's social situation which helps them to individualize their approach to him and understand him more fully as a person. It also is the means by which the medical social worker selects patients who need and are able to use casework services. However, a danger in this method is that the staff of the social service department may not be large enough to carry out both the initial social evaluation and continued casework services for selected patients. Another hazard in hospitals offering generalized care is that the problem of the person whose handicap is not extensive but whose particular life situation makes it a serious one to him, may be overlooked.

Irrespective of the method of referral, participation by the medical social worker on staff ward rounds and clinic conferences is found to be helpful in promoting continuity in teamwork. Neither the initial medical social casework evaluation nor participation on ward rounds is sufficient, however. There is no substitute for regular staff conferences, which provide the means for review of those patients' situations where a combination of medical and social needs require thoughtful consideration from a long-range point of view.

The conference method has long been an accepted procedure in rehabilitation institutes and certain specialized medical institutions, such as the tuberculosis sanatorium. Its use is discussed in a publication referred to previously¹⁹ and also in *Medical Social Service in Tuberculosis Control*.²⁰

Rehabilitation is a teamwork job in which several profes-

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sions participate, but not necessarily all at the same time. The leader of the team is the physician and all other services are based on his diagnosis and recommendations. Among the important members of the team are the nurse, medical social worker, occupational therapist, rehabilitation counselor, teacher, and many others who are concerned with the patient in the institution. At times, representatives of outside agencies may participate in the process. The medical social worker, an essential member of this team, assumes responsibility for the social aspects of service. . . .

A staff conference under the leadership of the physician enables each member of the team to make his particular contribution in developing the plan for the individual patient. This type of group discussion is a prerequisite for any vocational referral, which may take different forms: intraining, education, or retraining while the patient is in the sanatorium or after he is discharged, or assistance in job placement.²⁰

What is helpful to the patient with tuberculosis is also applicable to many persons with other kinds of physical impairments. The orthopedic unit of a large medical center operates a vocational guidance department not only for its own hospital and clinic patients but also for selected cases referred by the division of vocational rehabilitation and other appropriate community agencies. The team within the institutional setting consists of the orthopedist, psychiatrist, psychologist and medical social worker. Group conferences are arranged with representatives of the community agencies interested in each individual studied. This might include not only the worker from the division of vocational rehabilitation but others, "such as family case workers, medical social workers, and teachers . . . Recommendations are based upon the joint thinking of the group and are carried out by the appropriate agencies with the help of the psychologist and medical social worker when indicated. This department within an orthopaedic hospital, which cares prin-

cipally for children but carries the treatment through early years of adult life, was organized because it was realized that many patients who received medical care would not derive full benefit of that care unless they were given this specific service to help them to find their place in the community.”²¹

One hospital sets aside a weekly conference period attended by the professional staff, and a representative of the division of vocational rehabilitation. The physician and medical social worker collaborate in the selection of three patients whose need for joint consideration seems most urgent. The medical social worker prepares the summary of the patient's personal situation, the physician supplies the medical data. These conferences are, in a sense, previews of potential candidates for training by the rehabilitation agency. As a result of the discussion suggestions are often made regarding other services which would be helpful to the patient before or concurrent with a formal referral to the rehabilitation agency.

The medical social worker, then, is a member of the rehabilitation team and offers social casework service to or consultation on behalf of persons with physical impairments. Wherever she is used, in the hospital, clinic, rehabilitation center, vocational rehabilitation agency, crippled children's service or tuberculosis sanatorium, the social worker relates her understanding of the individual to the meaning of the physical impairment in his particular life situation. Her evaluation, as to the person's social, emotional and environmental needs, is considered in the planning among all experts on the team. Her services can be utilized best when there is a clear understanding on the part of other members of the team as to where and how and when she can be helpful, and when the medical social worker has an equally clear understanding of the contribution of others. Understanding grows through established patterns of working together.

Effective teamwork takes time. There is no short-cut method to thoughtful, long-range planning which requires discussion among various experts in the field of rehabilitation.

Teamwork in Community Planning

Teamwork in community planning, as in helping the individual to rehabilitate himself, is dependent upon mutual understanding of the value of all expert services which may be required for the total restoration of persons with physical impairments. Interagency agreements between public and voluntary agencies providing funds and services, formulated at the top-level of administration may provide the guideposts for prevention of duplication and gaps in service. However, unless those giving direct services contribute to the thinking which goes into top-level planning, the end result may be nothing more than lip service to principles which are recommended. To be truly dynamic, community planning must be a two-way affair, with experience on the direct service level influencing top-level recommendations.

Advisory committees with wide representation are of great value to voluntary and public agencies in formulating policies concerned with services which shall be rendered or the circumstances under which funds shall be used for payment of services. Workshop committees, made up of a cross section of experts providing direct services, present a rich opportunity for gathering factual material which can be used further to clarify functions between agencies, to stimulate better co-ordination of services, and to consider needed expansion of facilities in any given community. These workshop committees may be a part of the program of a welfare council or they may be initiated by the public and voluntary agencies that include co-ordination of services in their functions such as the crippled children's service or the division of vocational rehabilitation. The need for cross section planning between specialized and generalized services is continuous and it should be carried on at all levels of the administration of services.

In the words of an authority on community organization, "collaboration at the treatment level paves the way to co-operative effort in the community organization process."²² It is not enough to have interagency planning at the top. Workshop

committees are often the means by which the words "co-ordination" and "avoiding duplication" take on a real and dynamic meaning.

We can never brush aside the old and start with a clean page. We must carry along with us the reclaiming aspects of rehabilitation at the same time we are working on the preventative phases, whether it be on behalf of the individual or in terms of community planning. All the services and facilities needed will not suddenly spring up overnight for the use of those who are ready to take them on. Like the person with the impairment himself, we who are helping him must concentrate on what we have and what is possible for the future on a realistic basis.

An understanding of what exists now in the way of rehabilitative services and desirable goals toward which to work should be a part of the equipment of all persons who have any responsibility for provision of services, whether they are administrators, consultants, practitioners or volunteers. Welfare councils and other voluntary and public organizations on a local and national level provide the machinery for evaluating existing resources and considering future goals. What are the gaps in rehabilitative services in your community? What is the pattern of working together to extend existing services and create new ones which may be necessary? What part are you playing in the promotion of teamwork on behalf of the individual in need of direct services as well as on a community-planning basis?

6

Conclusions

IT IS HOPED that the material presented in this book has highlighted some of the personal factors involved in the rehabilitation of the individual with a permanent physical impairment as well as the importance, to him, of early use of appropriate services.

Since persons with physical impairments are first of all human beings, each with his own particular life situation and personality pattern, success or failure in rehabilitation will be influenced not only by the availability of specialized rehabilitative services, but also by the individual's ability to make use of these services. Where there are environmental, social and emotional problems which appear to stand in his way, the medical social worker, as one member of the rehabilitation team, may be able to help him work out a solution to his difficulties. This solution may require that he use social casework services, recreational or other facilities which are available through a wide variety of public and voluntary community resources.

Not all persons need social casework services in order to use other specialized rehabilitative facilities. Many individuals can and do avail themselves of vocational guidance and placement services, for instance, and achieve satisfying and useful lives without other help. On the other hand, some people have such deep-seated personality difficulties that they can only be helped through psychiatric treatment. Here the social caseworker may pave the way for an individual to seek psychiatric treatment when, at first, he does not see its value for him. In between are those individuals whose personal problems may be decreased through their use of social casework services. Early recognition of signs and symptoms of personal difficulties by all members

of the rehabilitation team may prevent prolonged, unnecessary suffering in the lives of those who have not only physical impairments but social and emotional handicaps as well.

The hospital or other agency providing medical care is often in a strategic position to recognize personal problems in the life of an individual who is seeking a specialized service designed to minimize his physical handicap. Physical restoration is often the first step toward total rehabilitation. A man or woman who has difficulty in accepting medical treatment may have personal problems which stem from family responsibilities or fears which are related directly to the implications for him, of the physical impairment. He may express his need for help in working out these problems in a variety of ways—he may seem fearful, emotionally upset, irritable, critical or apathetic. He may discuss his personal difficulties with members of the medical and nursing staff and others who assist in his care. A medical social worker who is a member of the staff of the medical care agency can, in co-operation with other members of the medical team, help the patient to work through some of these problems. This frequently influences the effectiveness of the medical treatment and strengthens the patient's personal resources so that he can take the next steps toward independence more easily.

From the point of view of prevention, it is important to call attention to the fact that many adults have been born with permanent handicaps, or have acquired them in childhood. When it is necessary for a child to leave his own home and spend a period of time in an institution, his eventual rehabilitation is facilitated immeasurably when the program of the institution makes it possible for him to continue to grow, socially and emotionally, when consideration is given to maintaining close ties between the child, his parents and other members of the family group during the separation and when he is helped to make the transition from the institution back to his own home. The child's or parents' fears regarding medical treatment, resentment of the limitations imposed by the impairment, over-protection of the child on the basis of the physical impairment, resistance to certain aspects of the program such as

speech training or physical therapy may come to the attention of other members of the medical team at various times during the course of treatment either in the institution or while attending clinic. An adequately staffed social service department in a medical center treating children is one of the ways of contributing toward prevention of disabling attitudes in adults.

The medical social worker, whether offering direct social casework service or consultation, may also be helpful to other members of the rehabilitation team through contributing to their understanding of the individual. Individuals can be helped to make the most of their capacities if all those who are helping them, figure out how to modify possible long-range plans, in the light of personal handicaps as well as physical and intellectual limitations and capacities. This requires a high degree of teamwork on the part of all who are offering services.

And finally, the medical social worker may join with others in community planning which is designed to develop, extend and improve services for the total rehabilitation of individuals with permanent physical disabilities. There is still much for all of us who are interested in persons with physical impairments to do in the way of making services available which will enhance the possibilities of total rehabilitation.

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- ⁶ Shimberg, Myra E.: Health and Employment: A Study of Public Assistance Clients Attending Out-Patient Clinics, Livingston, N. Y., Livingston Press, 1946. Especially Chapters III, IV, and VII.
- ⁷ For further information, an exhaustive bibliography has been prepared for distribution by the National Society for Crippled Children and Adults, Inc., 11 South La Salle St., Chicago 3, Illinois. This agency also maintains a loan library of many of the articles and books included in the bibliography which is available on request. Copies of "The Farthest Corner," an excellent brief summary, may be secured free of charge. The story, with photographs, of the care required by his child with cerebral palsy is presented by Mr. Ralph J. Amdursky in Pageant Magazine, May 1946: "Children in the Shadow," pp. 22-31.
- ⁸ Pattison, H. A.: Rehabilitation of the Tuberculous, Livingston, N. Y., Livingston Press, 1942, p. xi.
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